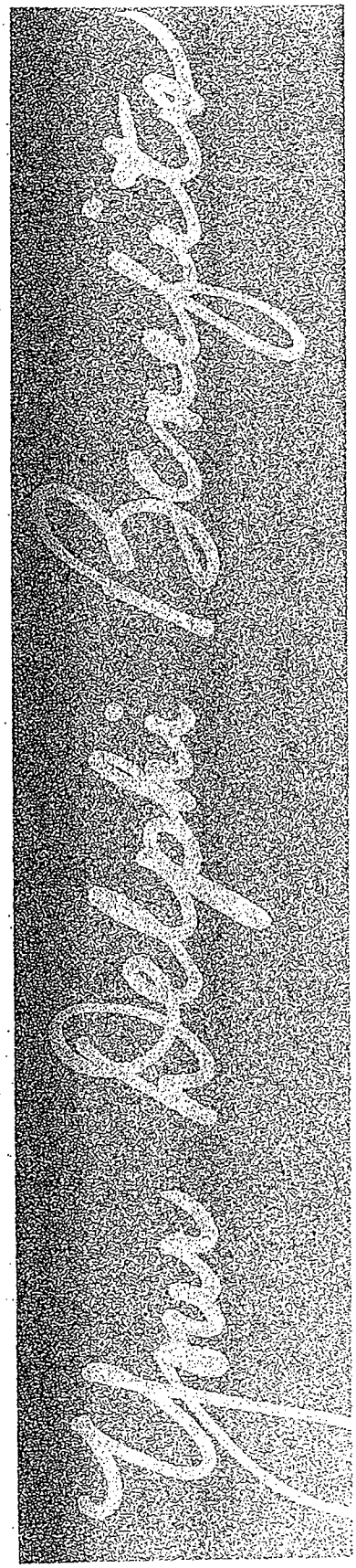

Summary Plan Description

For salaried employees hired on or
before December 31, 2000 and/or
with a service date on or before December 31, 2000

DELPHI
Automotive Systems

DELPHI
Automotive Systems

Dear Delphi Salaried Employee:

At Delphi Automotive Systems, the benefits you receive represent an integral and valuable part of your total compensation...

"Your Delphi Benefits" provides a summary of these benefits as well as some other items available to Delphi salaried employees.

Delphi recognizes that benefits are very important to you and your family. Because of this, the benefits package Delphi provides is both comprehensive and competitive — with a focus on quality, value and customer satisfaction. And, for many of the benefits offered, you have the flexibility to choose the options and coverage levels that best meet the needs of you and your family.

This booklet provides useful information that can help you make important benefit decisions during the annual enrollment period and throughout the year. Keep it as a reference tool to help answer any questions you may have — and as a resource on where to go for more information.

Remember, Delphi is committed to providing benefit options designed to help protect you and your family — but it's the choices you and your family make that ultimately define the value of those benefits. I encourage you to review the material covered in this booklet so you can gain a better understanding of your benefit program and make informed benefit decisions.

If you have any questions, please contact the appropriate resource as listed on page iii.

Sincerely,

Kevin Butler

Your Benefits As A Delphi Salaried Employee

This booklet presents general information only and is designed to give you a broad picture of the added value of working with Delphi Automotive Systems Corporation. It is not a contract and does not modify your month-to-month employment relationship or the terms of any benefit Plan or Program. Any reference to the payment of benefits is conditioned upon your eligibility to receive them. Each of these Plans or Programs has its own terms and conditions which in all respects control the benefits provided. Delphi Automotive Systems Corporation reserves the right to amend, change, or terminate the Plans and Programs described in this booklet. The Plans and Programs can be amended only in writing by an appropriate committee or individual as expressly authorized by the Board of Directors. No other oral or written statements can change the terms of a benefit Plan or Program.

The Salaried Retirement Program, Savings-Stock Purchase Program, and Delphi Options! Program may be subject to receipt of acceptable governmental rulings.

The information in this booklet generally is applicable to Delphi Automotive Systems regular salaried employees employed on or before December 31, 2000 and/or with a length of service date on or before December 31, 2000. Life, disability, and health care benefits described in this booklet generally are provided to regular salaried employees of Delphi Automotive Systems who are actively at work on or after January 1, 2000.

For each of the Plans and Programs described in this booklet, the term "employees" shall not include contract employees, bundled services employees, consultants, individuals who have represented themselves to be independent contractors, persons who the Corporation does not consider to be employees, or other similarly situated individuals regardless of whether the individual is a common law employee of the Corporation.

Telephone Numbers and Websites

Savings Stock Purchase Program		
■ Investment Service Center	1-877-389-2374	www.delphi401k.com
■ Investment Service Center (TTY)	1-800-655-0969 (TTY)	
■ Investment Service Center (Overseas)	1-606-282-8946 (Collect)	
Personal Retirement Income Plan (Putnam)	1-877-711-1885	www.delphiira.com
College Advantage Plan (Putnam)	1-877-711-1885	www.delphiira.com
Financial Planning (AYCO)	1-800-437-6383	www.aycofinancialnetwork.com/afpc/delphi
Flex Spending Accounts	1-800-435-3946	www.delphinbc.com
Flex Spending Accounts (TTY)	1-800-872-8682 (TTY)	
Health Care		
■ National Benefit Center (NBC)	1-800-435-3946	www.delphinbc.com
■ National Benefit Center (NBC)	1-800-872-8682 (TTY)	
■ COBRA Unit @ NBC	1-800-537-5865	
■ Extended Care Coverage (Connecticut General)	1-800-523-4626	
■ Long-Term Care (John Hancock)	1-800-611-9532	
■ Vision Plan (MetLife)	1-800-638-0166	www.delphinbc.com
■ Traditional Dental Plan (JLT Services)	1-800-280-8993	
■ Specialty carriers for BMP, EMP & PPO		
– Care Management (Health International)	1-877-405-0134	
– DME/P&O Network (Northwood NPN)	1-800-936-9316	
– Mental Health and Substance Abuse (CIGNA Behavioral Health)	1-888-865-2960	
■ Prescription Drug Coverage for BMP, EMP, PPO & POS		
– Mail Order Prescription Drugs (M.O.P.D.)	1-800-711-3459	www.merckmedco.com
– Member Services	1-800-711-3459	
■ Medicare	1-800-Medicare	www.Medicare.gov
■ Wellness and Health Promotion (LifeSteps)	1-800-711-5934	www.lifesteps.com
Basic Life, Optional Life, Dependent Life and Personal Accident Insurance		
■ Reporting a death	1-800-633-3900	
■ Reporting a death (TTY)	1-800-872-8682 (TTY)	
■ Inquiries	1-800-435-3946	www.delphinbc.com
■ Inquiries (TTY)	1-800-872-8682 (TTY)	
■ MetLife's Total Control Account Program®	1-800-435-3946	www.delphinbc.com
■ MetLife's Total Control Account Program®(TTY)	1-800-872-8682 (TTY)	
Sickness and Accident Benefits	1-800-734-0346	www.delphinbc.com
Sickness and Accident Benefits (TTY)	1-800-882-3563 (TTY)	
Extended Disability Benefits	1-800-734-0346	www.delphinbc.com
Extended Disability Benefits (TTY)	1-800-882-3563 (TTY)	
Supplemental Extended Disability Benefits	1-800-734-0346	www.delphinbc.com
Supplemental Extended Disability Benefits (TTY)	1-800-882-3568 (TTY)	
Retirement Program		
■ Pension Administration Center	1-800-659-2000	www.pension-administration.com
■ Pension Administration Center (TTY)	1-800-659-8811 (TTY)	
■ Retiree Servicing Center	1-800-828-9236	www.delphinbc.com
■ Retiree Servicing Center (TTY)	1-800-872-8682 (TTY)	
Salaried Dependent Scholarship Plan	1-888-502-8095	ww6.edcor.com/DLP/
Salaried Tuition Assistance Program	1-888-502-8095	ww6.edcor.com/DLP/
Stock Options	1-877-433-5744	www.benefitaccess.com
Wage and Employment Verification	1-800-886-3913	

USE your Social Security number in all of your communications to Delphi Automotive Systems.

CONTACT your local Social Security office if you have any questions about Social Security, or Medicare at www.ssa.gov or call 1-800-772-1213.

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Your Delphi Automotive Systems Benefit Program is made up of plans and programs designed to work together to help you meet many personal and financial needs now and in the future.

These plans can help you through various events in your lifetime. Page numbers are provided for your reference.	Lifetime Event						
	Saving For Your Future	If You Need Health Care	If You Become Disabled	If You Retire	Social Security Information	In The Event of Death	Your Surviving Spouse's Coverage
	Page	Page	Page	Page	Page	Page	Page
Savings-Stock Purchase Program	2		81	96		109	109
Delphi Options! Program			25	25	24	25	
Spending Accounts	20	20	25	25	24	25	
Health Care Program		31	81	97	65	111	112
Disability Coverages		80	75	82	78		
Retirement Program	96	97	82	84	94	93	107
Life Insurance Coverages			81	97		100	100

Events That May Require Action

Benefit	Delphi Servicing Centers to Contract	Change in Marital Status	Birth or Adoption of a Child	Death of a Dependent	Death of Employee	If You Become Disabled	If You Become Terminally Ill	If You Wish to Change Beneficiaries	Employment Status Change, You or Your Spouse
Health Care	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Add/Delete Dependent	Add Dependent	Delete Dependent			Review Hospice Coverage		Review Enrollment Decision
Flexible Spending Accounts	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Review Account Balance	Review Account Balance	Review Account Balance					Review Contribution Rate and Account Balance
Basic Life Insurance	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary			Review Applicability of A.B.O.	Contact NBC	
Optional Life Insurance	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary				Contact NBC	
Dependent Life Insurance	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Review Coverage and Amount	Review Coverage and Amount	Review Coverage and Amount					
Personal Accident Insurance	National Benefit Center Delphi Benefit Unit 1-800-435-3946	Review Coverage and Amount	Review Coverage and Amount	Review Coverage and Amount		Review Applicability of Benefit		Contact NBC	
Life Insurance Claims	National Benefit Center Delphi Benefit Unit 1-800-633-3900			Report Death	Report Death				
Disability	National Benefit Center Disability Unit 1-800-734-0346					Request Claim Form			
Salaried Retirement Program	Pension Administration Center 1-800-659-2000	Update Beneficiary	Review Beneficiary	Review Beneficiary	Report Death		Apply For Disability Retirement	Contact PAC	
Savings-Stock Purchase Program	Investment Service Center 1- 877-389-2374	Update Beneficiary	Review Beneficiary	Review Beneficiary	Report Death		Review Beneficiary	Contact ISC	Review Contribution Rate and/or Investment Options

Benefit election changes due to family status changes must be requested within 31 days of the event.

Your Capital Accumulation Opportunities

This section is designed to help you better understand various capital accumulation opportunities available to you as a Delphi salaried employee. The Savings-Stock Purchase Program (S-SPP) and the Putnam Personal Retirement Income Plan (PRIP) can be used to accumulate savings for your future financial security.

You will want to read these summaries carefully. After doing so, you will be better prepared to make decisions appropriate to your personal financial needs and goals.

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Savings-Stock Purchase Program

The purpose of the Savings-Stock Purchase Program (S-SPP) is to help you accumulate savings for your retirement, while at the same time providing you with an opportunity to acquire a stock ownership interest in Delphi. As an employee and owner of Delphi, your efforts contribute to the company's growth and prosperity. Therefore, as Delphi succeeds, you succeed.

Eligibility

You are eligible to participate in the S-SPP after you have completed six months of Delphi service and are (1) a regular salaried employee, (2) a flexible service employee, (3) a part-time employee, (4) a temporary employee. You are immediately eligible to participate if you are rehired after previously terminating employment from Delphi and you were previously eligible to participate in the S-SPP.

You are not eligible to participate in the S-SPP if you are an individual classified as a leased employee, contract employee, bundled services employee, consultant, individual who has represented yourself to be an independent contractor, person who the Corporation does not consider to be an employee, or other similarly situated individual regardless of whether you are a common law employee. You also are not eligible to participate in the S-SPP if you are an employee of a wholly owned or substantially wholly owned subsidiary of Delphi Automotive Systems Corporation which has not been approved for participation in the program by the Delphi Board of Directors.

Your participation in the S-SPP is voluntary. You may discontinue Program participation at any time.

Enrollment

If you are a rehired employee who was previously eligible to participate in the S-SPP and want to enroll immediately, you can access the enrollment kit online — through Apollo from a link on the Benefits Home Page or at www.delphi401k.com. Or, you can call the Delphi Investment Service Center toll-free at 1-877-389-2DPH.

Access to Your Account

When you participate in the S-SPP, you must establish, through the Delphi Investment Service Center, a confidential identification number that is personal to you (Personal Identification Number or "PIN"). This confidential PIN limits access to your S-SPP account to only you. You may, at any time, change your PIN. Moreover, you may only access your own account information and initiate transactions on the Internet or by telephone, using your confidential PIN and Social Security number. ***You should not give anyone your PIN.***

How the S-SPP Works

Employee Contributions

You may elect to contribute, through payroll deductions, up to 20% of your eligible salary into the S-SPP. Subject to tax regulations, ***your contributions may be made on a pre-tax basis, called Deferred Savings, or an after-tax basis, called Regular Savings,*** or any combination of pre-tax and after-tax payroll deductions. However, your total contributions may not exceed 20% of your eligible salary.

In addition, (1) cash payout amounts to which you may be entitled under the Incentive Compensation Plan (ICP) and (2) Flexible Compensation Payments (FCP) also may be contributed to the S-SPP. You may elect to contribute 100% of your ICP cash payout to your S-SPP account to the extent permissible under federal tax law. ICP cash payout amounts may only be contributed on a pre-tax basis. You may elect to contribute 100% of your FCP into your S-SPP account in 24 equal installment payments (or fewer if such installment payments terminate) during any calendar year a FCP is made by Delphi. The FCP will be made on a pre-tax basis until a tax law limit is reached, at which point any remaining FCP will be contributed on an after-tax basis to the extent permissible under federal tax law.

You may make Deferred and Regular Savings ***by payroll deductions only.*** You may change the amount of your contributions at any time. The amount you elect to contribute may be limited by federal tax law. You should review Tax Considerations on page 8 for more detail.

Delphi Contributions

The S-SPP has a provision where Delphi can "match" or, in other words, contribute to your account, a percentage of the amount you contribute up to 7% of your eligible salary. All Delphi matching contributions are invested in the Delphi Common Stock Fund. Effective May 1, 2001, the match is indefinitely suspended. This match is subject to change at the Corporation's discretion.

Your contributions above 7% of your salary are not matched by Delphi. Delphi also does not match your ICP or Flexible Compensation payment amount contributed to the S-SPP. (If you are a temporary employee, Delphi does not match any contributions you make to the S-SPP.)

If you were hired on or after January 1, 1993, and (1) have completed six months of service, and (2) are eligible to participate in the S-SPP, Delphi automatically contributes an amount equal to 1% of your eligible salary to your S-SPP account, whether or not you elect to participate in the S-SPP. This additional contribution, called the "1% Delphi Benefit Contribution," is provided because you are not eligible for Delphi contributions for post-retirement health care or life insurance. The 1% Delphi Benefit Contribution will be invested in the Delphi Common Stock Fund. If you are a flexible service employee, temporary employee, contract employee, bundled services employee, consultant, or independent contractor, you are not eligible for the 1% Delphi benefit contribution.

Delphi contributions (which hereinafter include "Delphi matching contributions" and the 1% Delphi benefit contribution unless otherwise specified) vest immediately upon allocation to your account if you have five or more years of Credited Service. If you have less than five years of Credited Service, Delphi contributions vest on January 1 following the calendar year in which such contributions are made, or, if earlier, upon your attaining five years of Credited Service. However, if you are part of a divestiture, split-off, or spin-off and you have less than five years of Credited Service, all assets in your account shall be fully vested at the time of such transaction.

Delphi contributions are required to be invested in the Delphi Common Stock Fund during the 12-month calendar year in which the contributions are made (January through December). This period is referred to as the ***"Required Retention Period."*** Upon completion of the Required Retention Period, you may exchange Delphi contributions invested in the Delphi Common Stock Fund among any of the over 70 investment options offered under the S-SPP.

Contributions From Other Qualified Plans

You may make a rollover contribution to the S-SPP once you are eligible to participate in the S-SPP. The rollover amount may not exceed the taxable portion of cash proceeds received (1) from your former employer's qualified savings plan, or (2) under a Qualified Domestic Relations Order from a qualified savings plan. Contributions of this kind must be made (1) by a "direct rollover" from the other qualified savings plan, or (2) within 60 days from the date you receive a distribution from the other qualified savings plan. Corporation matching contributions are not credited on any rollover contributions you make to the S-SPP.

Investment of Your Contributions

One-half of your contributions up to 7% of eligible salary must be invested in the Delphi Common Stock Fund and remain in such Fund during the Required Retention Period. The remainder of your contributions may be invested, as you elect, in 10% increments in any of the S-SPP's investment options.

Your investment option elections will remain in effect until you change them. The S-SPP provides you with the flexibility to change your investment options on any business day. A business day is any day during which the New York Stock Exchange is in operation.

The S-SPP provides you with a broad range of over 70 investment options, each with different return and risk characteristics. Delphi encourages you to familiarize yourself with the S-SPP's investment features. You should carefully read the S-SPP materials, including the prospectus, which is available on the S-SPP's web site (accessed through Apollo from a link on the Benefits Home Page or through the Internet at www.delphi401k.com). Or, you can call the Delphi Investment Service Center at 1-877-389-2DPH.

Familiarization with the S-SPP's investment features, coupled with the flexibility to change your investment options, as well as being able to exchange assets among investment options on any business day, will allow you to make informed investment decisions that will best meet your financial goals.

As an S-SPP participant, ***you are solely responsible for the selection of your investment options.*** When making your investment decisions, you are assuming the risks of potential losses, which may result from your decisions. Delphi and/or any of its agents are not empowered to advise you as to the manner in which your investments should be made. Additionally, the fact that an option is available for investment under the S-SPP should not be construed by you as a recommendation by Delphi for investment in that option.

You should note that the market value and the rate of return on each investment option fluctuates over time and in varying degrees. Accordingly, the proceeds, if any, you realize from such investments depend on the prevailing market value of the investments at a particular time, which may be more or less than the amount you invested initially. There is no assurance that any of the investment options will achieve their objectives or your objectives. You should note that each investment option is subject to varying degrees of risk, which are discussed in the S-SPP's prospectus.

Information About the Investment Options

General Motors Asset Management Corporation, a wholly owned subsidiary of General Motors Corporation, advises Delphi in developing the S-SPP investment options and has overall responsibility for monitoring the investment options.

Currently, over 70 investment options are available to you in the S-SPP. With so many investment options from which to choose, individual fund selections can be challenging. To help narrow your choices to a set of funds that may be right for you, the S-SPP investment options are organized into three Pathways. Although the three Pathways lead to different groups of investment options, all the investment options in the S-SPP are available to you at any time. You can mix options from any of the three Pathways.

Pathway One

Includes four Promark Target Portfolios and six Fidelity Freedom Funds that are each designed to be a single choice option that produces a diversified portfolio. You may want to consider these option choices if you are new to investing, unfamiliar with investment concepts, or looking for diversified investment choices that require minimal involvement by you.

Pathway Two

Includes option choices you may want to consider if you have some knowledge of investing and asset allocation and you wish to select from Delphi Common Stock Funds and a group of style-specific funds, known as the Promark Funds. These options are designed to offer you the "building blocks" for a well-diversified portfolio.

Pathway Three

Includes option choices you may want to consider if you are an experienced investor who wishes to build a customized, diversified portfolio from a large selection of Fidelity and other mutual funds, and you have the time to select and actively monitor your portfolio.

Available Investment Options

A listing of the investment options currently available under the S-SPP, depicted by Pathway category, is listed on the next page. **Before you invest in a fund, please read the relevant prospectus for the fund.** A detailed description of each of the Promark Funds and the Delphi Common Stock Fund is contained in the S-SPP Prospectus. A detailed description of the Fidelity and other mutual funds is included in the individual mutual fund's prospectus.

Prospectuses can be obtained by accessing the S-SPP web site through Apollo from a link on the Benefits Home Page or through the Internet at www.delphi401k.com. Or, call the Delphi Investment Service Center at 1-877-389-2DPH.

Pathway One

Code	Fund Name
	PROMARK TARGET PORTFOLIOS
(96297)	Promark Target Portfolio: Income
(96295)	Promark Target Portfolio: Conservative Growth
(96298)	Promark Target Portfolio: Moderate Growth
(96296)	Promark Target Portfolio: Dynamic Growth

Code	Fund Name
	FIDELITY FREEDOM FUNDS®
(00369)	Fidelity Freedom Income Fund®
(00370)	Fidelity Freedom 2000 Fund®
(00371)	Fidelity Freedom 2010 Fund®
(00372)	Fidelity Freedom 2020 Fund®
(00373)	Fidelity Freedom 2030 Fund®
(00718)	Fidelity Freedom 2040 Fund®

Pathway Two

Code	Fund Name
	U. S. EQUITY FUNDS
(96288)	Promark Large Cap Blend Fund
(96290)	Promark Large Cap Value Fund
(96289)	Promark Large Cap Growth Fund
(96325)	Promark Large Cap Index Fund
(96323)	Promark Social Equity Fund
(96291)	Promark Mid Cap Blend Fund
(96294)	Promark Small Cap Value Fund
(96293)	Promark Small Cap Growth Fund
	U.S. FIXED INCOME FUNDS
(96326)	Promark Income Fund
(96285)	Promark High Quality Bond Fund
(96286)	Promark High Yield Bond Fund

Code	Fund Name
	INTERNATIONAL EQUITY FUNDS
(96287)	Promark International Equity Fund
(96284)	Promark Emerging Markets Equity Fund
	SPECIALTY/SECTOR FUNDS
(96283)	Promark Balanced Fund
(96292)	Promark Real Estate Securities Fund
	COMPANY STOCK FUNDS
(94005)	Delphi Common Stock Fund
(94018)	GM $1-2/3 Par Value Common Stock Fund†
(94024)	GM Class H Common Stock Fund†
(94034)	EDS Common Stock Fund†
(94029)	Raytheon Company Class A Common Stock Fund†

†No new contributions or exchanges are permitted into these funds.

Pathway Three

Code	Fund Name
	U. S. EQUITY FUNDS
(93967)	Domini Social Equity Fund
(00324)	Fidelity Aggressive Growth Fund
(00312)	Fidelity Blue Chip Growth Fund
(00307)	Fidelity Capital Appreciation Fund
(00022)	Fidelity Contrafund
(00315)	Fidelity Disciplined Equity Fund
(00330)	Fidelity Dividend Growth Fund
(00023)	Fidelity Equity-Income Fund
(00319)	Fidelity Equity-Income II Fund
(00332)	Fidelity Export and Multinational Fund
(00500)	Fidelity Fifty
(00003)	Fidelity Fund
(00025)	Fidelity Growth Company Fund
(00027)	Fidelity Growth & Income Portfolio
(00316)	Fidelity Low-Priced Stock Fund
(00021)	Fidelity Magellan Fund
(00337)	Fidelity Mid-Cap Stock Fund
(00093)	Fidelity OTC Portfolio
(00073)	Fidelity Retirement Growth Fund
(00336)	Fidelity Small Cap Selector
(00320)	Fidelity Stock Selector
(00005)	Fidelity Trend Fund
(00039)	Fidelity Value Fund
(93895)	Newberger Berman Socially Responsive Trust
	U. S. FIXED INCOME FUNDS
(00038)	Fidelity Capital & Income Fund
(00453)	Spartan Government Income Fund
(00448)	Spartan Investment Grade Bond Fund

Code	Fund Name
	INTERNATIONAL EQUITY FUNDS
(00309)	Fidelity Canada Fund
(00325)	Fidelity Diversified International Fund
(00322)	Fidelity Emerging Markets Fund
(00301)	Fidelity Europe Fund
(00305)	Fidelity International Growth & Income Fund
(00094)	Fidelity Overseas Fund
(00302)	Fidelity Pacific Basin Fund
(00318)	Fidelity Worldwide Fund
	INTERNATIONAL FIXED INCOME FUNDS
(00451)	Fidelity International Bond Fund
(00331)	Fidelity New Markets Income Fund
	SPECIALTY/SECTOR FUNDS
(00328)	Fidelity Asset Manager: Income
(00314)	Fidelity Asset Manager
(00321)	Fidelity Asset Manager: Growth
(00304)	Fidelity Balanced Fund
(00308)	Fidelity Convertible Securities Fund
(00334)	Fidelity Global Balanced Fund
(00004)	Fidelity Puritan Fund
(00303)	Fidelity Real Estate Investment Portfolio
(00311)	Fidelity Utilities Fund

Fund Exchanges

Except as provided below, you may exchange all, or part, of your assets from one investment fund to other investment funds on any business day of the year.

- An exchange may be made in 1% increments. or whole dollar amounts. An exchange must consist of assets having a Current Market Value of $500, or if less, all the assets in the investment fund.

- Delphi contributions, as well as earnings on such contributions, required to be invested in the Delphi Common Stock Fund may not be exchanged until completion of the Required Retention Period.

Delphi reserves the right to modify or suspend exchanges involving any one or more of the Promark Funds and the Delphi Common Stock Fund offered under the S-SPP in those instances where trading in such fund(s) might adversely impact the operation or investment returns of such fund(s) or exceed the available liquidity for such fund(s). Furthermore, Fidelity and the other mutual fund providers reserve the right to modify or suspend exchanges among their mutual funds as described in their prospectuses. Fidelity and other mutual fund providers also reserve the right, under circumstances described in their prospectuses, to suspend or delay purchases and/or redemptions from their mutual funds, which might in turn delay your exchanges to or from the Promark Funds or the Delphi Common Stock Fund. Effective December 1, 2000, the Delphi Common Stock Fund imposes a 1% redemption fee on assets that are held less than 30 days. This redemption fee is deducted from the assets redeemed. The redemption fee is paid to the Fund, and helps protect the Fund's performance and shareholders by discouraging frequent trading in response to short-term market fluctuations.

Loans

Once each calendar year you may borrow from assets in your account. You may have up to five outstanding loans at any one time. The loan may be for any reason. No credit statement is required. Amounts borrowed are not subject to income tax, except in the case of a loan default. Delphi contributions subject to the Required Retention Period cannot be borrowed.

The minimum loan amount is $1,000. You may not have, at any time, outstanding loans exceeding the maximum of $50,000. You may apply for a loan for an amount which is the lesser of:

- $50,000 less the highest amount of loans you had outstanding during the prior 12 months; or

- One-half of the current market value of your total vested assets.

The interest rate payable on a loan is the prime interest rate prevailing as of the last business day of the quarter immediately preceding the date that a loan is requested. The prime rate is the rate charged to a bank's best customers. The interest rate will remain fixed for the duration of a loan.

Cash for your loan is obtained by selling assets in your account. The assets to be sold are selected by you. If you do not make a selection, a pro-rata amount of the assets in your account will be sold.

Amounts repaid are allocated to your account based on the investment options you elect for your current contributions. However, the portion of repaid amounts obtained from assets required to be invested in the Delphi Common Stock Fund must be reinvested in the Delphi Common Stock Fund if still subject to the Required Retention Period.

Repayment of a loan is made through after-tax payroll deductions. The minimum repayment is $50 per month, over a period of time you elect. Generally, the repayment period ranges from six months to five years. You have up to 10 years if the loan is to purchase or build your principal residence. There are no prepayment penalties if you repay the loan earlier than scheduled.

In the event you fail to make a required loan payment and your failure to make such loan payment continues beyond the last day of the calendar quarter following the calendar quarter your required loan payment is due, your loan shall be considered in default and you shall be irrevocably deemed to have received a distribution of assets in an amount equal to the outstanding balance of the loan, plus any accrued interest, calculated to the date the loan is deemed distributed. Prior to defaulting on an outstanding loan, a notice will be sent to you providing you with a repayment opportunity ***unless*** the failure to repay the loan is a result of your bankruptcy.

Please note that defaulting your outstanding loan balance may result in tax consequences for you.

Withdrawals

A withdrawal of assets is permitted, subject to certain limitations. These limitations are designed to comply with federal regulations. Withdrawals may also be subject to tax penalties.

During the Required Retention Period, you may withdraw part, or all, of your Regular Savings and earnings thereon, at any time, without restrictions. You may withdraw your Deferred Savings only as described below. You may not withdraw any Delphi contributions or earnings thereon that are subject to the Required Retention Period. No forfeiture of any Delphi contributions will occur as a result of your withdrawal.

After the Required Retention Period, you may, subject to certain limitations on withdrawal of Deferred Savings, withdraw from your account part, or all, of your assets. This includes earnings on your contributions, as well as any Delphi contributions. However, if you have less than five years of Credited Service you may not withdraw all, or any part, of Delphi contributions that were contributed within the 24 months preceding the month of withdrawal.

You may withdraw part, or all, of your Deferred Savings and earnings thereon for any reason after you attain age 59-1/2. Prior to age 59-1/2, withdrawal of Deferred Savings may be made by you only in the event you have a "financial hardship" as defined by federal rules and the withdrawal is in order to:

- Purchase, or construct, your principal residence;
- Prevent foreclosure on, or eviction from, your principal residence;
- Pay medical expenses for you, your spouse, or your dependent(s) that are not covered under the SHCP; or
- Pay tuition for the next 12 months of post-secondary education for you, your spouse, or your dependent(s); or
- Any other reason permitted under IRS rulings and notices.

Any withdrawal of Deferred Savings for a hardship will be limited to the amount of your contributions. Earnings on Deferred Savings are not available for a hardship withdrawal. If you request a hardship withdrawal, you may include in the withdrawal any amounts necessary to cover the anticipated taxes and early withdrawal penalties resulting from the withdrawal. Before Deferred Savings can be withdrawn for a hardship, you must take all available asset distributions, withdrawals, and loans under all applicable plans maintained by Delphi. ***If you withdraw Deferred Savings because of a hardship***, you will be suspended from making further contributions under this Program and certain other Delphi benefit and compensation plans for a period of 12 months following the withdrawal. Furthermore, the maximum amount of Deferred Savings contributions you may make during the succeeding calendar year following the hardship withdrawal may be limited in order to comply with certain federal tax regulations.

How Assets Are Distributed

At distribution, you will receive the S-SPP assets to which you are entitled, in the following form:

- **Delphi Common Stock, GM Common Stocks ($1-2/3 Par Value and Class H), EDS Common Stock and Raytheon Class A Common Stock**
  In the case of a withdrawal, or upon receipt of a settlement at the termination of your employment, you may elect to receive (1) stock certificates registered in your name alone, or in your name with your spouse as a "joint tenant with right of survivorship," but not as "tenants in common," or (2) the current cash value of your stock fund(s).
- **Other Assets**
  Units to your credit in the Promark Funds always will be settled in cash. Shares to your credit in the Mutual Funds also will be settled in cash.

Restoration of Forfeited Delphi Contributions

If you terminate your employment from Delphi and are subsequently ***rehired and again become eligible to participate in the S-SPP*** before incurring five consecutive one-year breaks in service following termination, you may restore previously forfeited Delphi contributions. This may be accomplished through the repayment of the full amount of the distribution you received upon termination, or if no distribution of your assets occurred, upon your request to the Delphi Investment Service Center for such restoration. All repayments must be made before the earlier of five years after you are re-employed, or when you incur five consecutive one-year breaks in service following the date of the distribution. You should contact the Delphi Investment Service Center for additional information.

Voting Rights

Through the Trustee, you will be extended the right to vote all shares equivalent to the current value of assets invested in Delphi Common Stock. Before each respective stockholder meeting, you will be contacted by mail and asked for directions on how to vote shares equivalent to the current value of your investment in the above mentioned common stock. You may specify your directions by Internet, telephone or by completing and returning the proxy/voting instruction card that will be provided to you by mail. The Trustee will vote by proxy, with proper precautions to preserve the complete confidentiality of your vote. Shares of Delphi Common Stock for which you do not provide direction will be voted by the Trustee in the same ratio as shares with respect to instructions received from other S-SPP participants.

Account Statements and Tax Information

You will be furnished a statement four times per year reflecting assets credited in your account under the S-SPP or you may access your S-SPP account statement online 24 hours a day through Apollo from a link on the Benefits Home Page or the Internet at www.delphi401k.com. The online statement provides all the same information as the hardcopy statement, including your personal rate of return. Additionally, the online statement adds more flexibility — your account information can be retrieved monthly, quarterly or for a specific date or date range.

If you choose to access your statement online you will no longer receive a hard copy in the mail unless you specifically elect this option at a later date.

Tax information will be furnished to you from time to time during your participation in the S-SPP.

Tax Considerations

Delphi is required under current federal tax law to limit your pre-tax contributions. For 2001, the limit is $10,500. This amount may be periodically adjusted for subsequent calendar years, as provided by law. Other federal limits also apply and may result in a reduction of your after-tax and/or pre-tax contributions. If you are affected, your subsequent contributions until the end of the calendar year may be (1) re-categorized from pre-tax to after-tax, (2) reduced, or (3) refunded to you.

Delphi may not give tax advice to you and recommends that you seek the advice of a tax advisor.

Your S-SPP contributions are subject to Social Security (FICA) taxes. Also, you should be aware that under current tax laws, income taxes on (1) pre-tax contributions, (2) Delphi contributions, and (3) all earnings credited to your account are delayed until you receive a withdrawal or distribution. When you do elect a withdrawal or distribution, federal income tax will be withheld at a mandatory rate of 20% on the taxable amount of any withdrawal or distribution that is not directly rolled over, at your direction, into an Individual Retirement Account (IRA) or another qualified plan.

Under current tax law, a 10% additional early distribution tax will be imposed on the taxable portion of any Program withdrawal or distribution made when you are under age 59-1/2. The additional tax does not apply to (1) the non-taxable portion of a withdrawal or distribution, or (2) taxable monies you roll over, or elect to have directly rolled over, into an IRA or another qualified plan.

Moreover, the 10% tax does not apply to distributions that are:

- Made to you after you separate from service by retirement during or after the calendar year in which you attain age 55;
- Made to you because you have tax-deductible medical expenses (whether or not you itemize deductions);
- Paid to an alternate payee under a Qualified Domestic Relations Order;
- Made to you as a result of a federal tax levy;
- Paid to your Beneficiary after you die;
- Made to you because you are totally and permanently disabled; or
- Made to you as part of a series of substantially equal periodic (at least annual) payments over your lifetime or the joint lives of you and your Beneficiary and such payments begin after your separation from service and continue for five years or until age 59-1/2, whichever is later.

As a result of tax law changes, beginning January 1, 2001, five-year income averaging on lump-sum distributions has been eliminated. However, special averaging rules apply, both before and after January 1, 2001.

As an alternative to receiving a distribution, you can elect a "direct rollover" of all, or any portion, of the taxable amount of your S-SPP distribution into an IRA, or another qualified plan. If you do this, under current tax law, you would pay no tax at the time of distribution on the amount rolled over. However, if you choose to have all, or a portion, of your S-SPP assets paid to you, federal income tax will be withheld at a mandatory rate of 20% on the taxable amount of the distribution. If, after you receive your S-SPP distribution, you decide to roll over 100% of the taxable amount of such distribution into an IRA, or another qualified plan, you must provide the funds to replace the 20% that was withheld. This tax-free rollover must be accomplished within 60 days after your receipt of the distribution. Any amount rolled over will not be taxed under current tax law until you withdraw it from the IRA, or another qualified plan. However, any amounts withdrawn from an IRA at a later date would be subject to tax at ordinary income tax rates. Note: Hardship distributions may not be rolled over to an IRA or another plan.

If you retire or terminate your employment from Delphi, you may continue to defer distribution of all your assets until April 1 of the year following the year you attain age 70-1/2 (the time minimum annual distributions must commence for retired and terminated participants).

Benefit Payment Options When You Retire

Lump-Sum Distribution: You may elect to receive, in a lump sum, all assets in your S-SPP account, including Delphi's contributions.

Deferral of Distribution: At retirement, you may continue to leave your assets in the S-SPP. You may elect subsequently to receive your S-SPP assets in a lump sum at any time. **Upon attainment of age 65, if you still have assets in the S-SPP, you must elect to defer the distribution of your account; otherwise, it will automatically be distributed to you.** You will be notified, in writing, of your deferral election option prior to any automatic distribution.

During the period your assets remain in the S-SPP they may continue to grow on a tax-deferred basis. Moreover, you may continue to "manage" the assets in your account. You may (1) exchange assets among the various investment funds and (2) borrow from your assets, as permitted under S-SPP provisions. Any outstanding S-SPP loans you have at the time of retirement, or any new loans you may take thereafter, must be repaid, by making monthly cash payments. No loan repayments will be deducted from your Delphi retirement benefits. Rather, the Delphi Investment Service Center will send you loan repayment coupons for use when submitting your cash payment.

- **Installment Payments and Partial Distributions:**
  During the period your assets remain in the S-SPP you may elect to receive periodic installment payments from your account. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installments must be in whole dollar amounts and total at least $1,200 each year. You may, at any time, revise the amount and frequency of any such installments, or you may discontinue installment payments. Additionally, you may take a partial distribution of your assets at any time, either in addition to any installment payments you may elect or without installment payments.

- **Age 70-1/2 Minimum Distribution Requirement:**
  If you (1) defer receipt of your S-SPP assets and (2) later attain age 70-1/2 and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The first such minimum distribution payment will be made to you automatically, in December of the year in which you attain age 70-1/2, unless you elect to defer receipt of your first minimum distribution payment until no later than April 1 of the following year. Thereafter, depending upon the amount you withdraw voluntarily during the calendar year from your S-SPP account, a minimum distribution payment will be made to you in December each year.

When a minimum distribution is required from your S-SPP account this requirement will be satisfied in one of two ways. First, absent any installment or partial distribution(s) from your account in the year, a distribution equal to the minimum required amount will be paid to you in December of the year. Second, the cumulative amount of any voluntary (1) installment distribution(s) and (2) partial distribution(s) that you take from your account during the year will first be used to satisfy the legally required minimum amount applicable for such year.

The amount of your minimum distribution payment will be based upon your (1) account balance and (2) remaining life expectancy, unless you elect to have the payment based upon both your life and your S-SPP Beneficiary's life expectancies. You will be notified, in writing, prior to receipt of your initial minimum required distribution.

Individual Retirement Account

Another alternative available at retirement, is the "rollover" of the taxable amount of a S-SPP distribution to an Individual Retirement Account (IRA). Similar to the annuity option, an IRA will provide for deferred income. Any rollover of assets would be arranged between you and a bank or investment company of your choice. You should check with a financial advisor concerning the tax impact of distributions from an IRA and any applicable sales or commission charges.

Personal Retirement Income Plan

The Personal Retirement Income Plan (PRIP) provides Individual Retirement Accounts (IRAs) through the Putnam IRA Program sponsored and administered by the Putnam Funds of Boston, Massachusetts. The Plan provides you the opportunity to invest in a number of options through (1) payroll deduction, or (2) lump-sum contributions. Participation in the Plan is completely voluntary.

Eligibility

All salaried employees are immediately eligible upon their date of hire, to participate in the PRIP.

Delphi's Involvement

Without endorsing the PRIP, Delphi allows Putnam to publicize the features of the PRIP to employees and to collect contributions through payroll deductions and remit them to Putnam. The PRIP is not a Delphi employee benefit plan governed by ERISA. It is not sponsored, administered or reviewed by Delphi, and is not subject to Delphi's Plan appeal procedures. While Delphi does not endorse the PRIP or any of the investment options, it provides you the convenience of payroll deduction. No contributions are made by Delphi. For more detailed information about the PRIP, please access delphiira.com and review the "Learning Center" — "Why Putnam" information.

Investing In The Plan

Putnam has informed Delphi that the PRIP allows for contributions up to $2,000 each year, either through payroll deductions or lump-sum investments. In addition to opening an IRA for yourself, you also can open an account for your spouse. This is true whether your spouse is employed or not. The PRIP permits an annual investment of up to $4,000 for married couples.

If you participate, the minimum payroll deduction for PRIP contributions is $12.50 per payroll period, or $25 a month. The minimum lump-sum contribution is $500 ($250 per fund).

Putnam Fund prospectuses can provide you with details on each investment fund option.

Communications

Putnam has informed Delphi that it will provide you with a quarterly statement of information regarding your IRA account. In addition, Putnam will send you a report on fund performance for the Putnam family of funds semi-annually. This report offers updates on the funds and issues relating to the Putnam Program. Annual and semi-annual fund reports are sent to you for each of your Putnam mutual fund investments. These reports discuss recent market conditions and provide a listing of the funds' investment portfolios. For more detailed information about the Delphi PRIP, access the web site through Apollo from a link on the Benefits Home Page or at www.delphiira.com.

Questions

Questions or concerns regarding the Plan or taxes should be directed to Putnam. If you wish to enroll in the **Personal Retirement Income Plan**, you may access their web site through Apollo from a link on the Benefits Home Page or at www.delphiira.com, or call Putnam using the toll free number **1-877-711-1885.**

College Advantage Plan

The Putnam *College Advantage* Plan is a new plan that allows an employee a way to save for college that takes advantage of Section 529 of the Internal Revenue Code. The Plan provides: tax-free accumulation and helps reduce estate taxes. Participation in the Plan is completely voluntary.

Eligibility

All salaried employees are immediately eligible upon their date of hire to participate in the *College Advantage* Plan.

Delphi's Involvement

Without endorsing the College Advantage Plan, Delphi allows Putnam Investments to publicize the features of the Plan to employees. Contributions may not be made through payroll deductions, but must be remitted directly to Putnam. Putnam has informed Delphi that it will waive sales commissions for investments. This plan is not a Delphi employee benefit plan governed by ERISA. It is not sponsored, administered or reviewed by Delphi and is not subject to Delphi's appeal procedures.

Brief Summary of the Plan

The Putnam *College Advantage* Plan combines tax benefits with professional portfolio management and allows you to control withdrawals for the life of the account. Anyone can contribute, including parents, grandparents, other relatives and family friends. You can use the account to pay for education regardless of your age or to help another adult go back to school.

Beginning in 2002 and thereafter, account earnings are tax-free and withdrawals for qualified educational expenses are free from federal income tax; however, state income taxes may continue to apply. Contributions can be as low as $15 per month. Contributions will be set-up by Putnam through an Electronic Funds Transfer (EFT) from your bank account.

To get more detailed information about the Plan, simply request the educational material from Putnam.

Educational Material/Enrollment

To receive educational material about the *College Advantage* Plan, you may call Putnam's toll free number at 1-877-711-1885. Employees may enroll on-line at the Delphiira.com website or by calling Putnam's toll free number at 1-877-711-1885.

Account Statements

Putnam has informed Delphi that employees will be sent a quarterly statement of information regarding their *College Advantage* account. Putnam will also send you a report of fund performance.

Questions About the Plan

If after receiving Putnam's educational material on the *College Advantage* Plan, you still have questions, please contact Putnam directly at 1-877-711-1885.

Financial Planning

The Financial Planning Option provides you access to personalized financial planning service. The Ayco Company of Albany, New York sponsors and administers the Financial Planning Option. You are provided the opportunity during the annual benefit enrollment to select any of two options and remit payment to Ayco through payroll deduction. Participation is completely voluntary.

Eligibility

The Financial Planning Option is available only to regular active employees, flexible service employees and cooperative students who are either: (1) U.S. residents, or (2) expatriate personnel.

Delphi's Involvement

Without endorsing the service, Delphi allows Ayco to publicize the features of its service to employees and to collect contributions through payroll deductions and remit them to Ayco. The Financial Planning service provided is not a Delphi employee benefit plan governed by ERISA. It is not sponsored, administered, or reviewed by Delphi and is not subject to Delphi's appeal procedures. While Delphi does not endorse the service or any of the Financial Planning Options, it provides you the convenience of payroll deduction. No contributions are made by Delphi.

Financial Planning Options

Annually, only during the Delphi annual enrollment period, you have the opportunity to elect one of the two following options, with payment for the elected Option being available only through payroll deduction:

- **Life-Event Financial Planning**
  Ayco has informed Delphi that this option provides low-cost access to an experienced financial planner via *The Ayco AnswerLine®*. Participants can get personalized, professional advice on any planning issues, including company benefits and the financial implications of such life events as getting married, buying a home, preparing for a child's education, helping aging parents and planning for retirement. Personalized, topic-specific Focus Reports provide an objective assessment of your current financial situation (including stock-option planning). Their planners can help you make decisions as well as develop a set of personalized action items to put your financial planning in motion.

  This option includes:
  - "Welcome" letter and brief questionnaire
  - Personalized financial counseling via *The Ayco AnswerLine®* (up to 3 hours annually)
  - *Ayco's Updates* newsletters (10 issues)
  - *The Ayco-Approved List of Mutual Funds;* and
  - Access to topic-specific reports on retirement, asset allocation, education and life insurance.

- **Comprehensive Financial Planning**
  Ayco has informed Delphi that the Comprehensive Service combines the planning benefits of one-on-one financial counseling with the interactive power of the *Ayco Financial Network*, a password-protected website that acts as your financial mentor and redord-keeper. Through *The Ayco AnswerLine®*, you can get personalized, professional advice on any planning issues. *Aycofn.com*[SM] provides "do-it-yourselfers" with the tools that they need to assess their financial fitness while guiding them through the steps they need to take. It also allows users to keep a secure, easily updatable record of their progress and features a variety of financial modeling tools, including the *Online Financial Plan* and interactive calculators.

The *Online Financial Plan* allows you to enter your data through an online questionnaire. You can model multiple scenarios as life events occur and access Ayco's online reference library on cash flow, investments, estate planning, insurance, education funding, tax planning and key life events. Using the *Online Financial Plan* in conjunction with an *AnswerLine* planner provides cost-effective assistance in putting your financial house in order.

This option includes:

- All services provided under Life-Event Financial Planning;
- Unlimited access to the *Ayco Financial Network;*
- The *Online Financial Plan;* and
- A complimentary copy of the *Investing in Your Future* guidebook, a comprehensive planning reference.

Questions

Questions or concerns regarding there **Financial Planning** options or taxes should be directed to Ayco. You may access their website through Apollo from a link on the Benefits Home Page or at www.aycofinancialnetwork.com/afps/Delphi — or call Ayco using the toll-free number **1-800-437-6383.**

Your Flexible Compensation Payment

The Flexible Compensation Payment (FCP) is designed to provide you increased flexibility in managing your total compensation. With the FCP you have the opportunity to receive cash in several options and/or generally, exchange a portion of it for additional days off. The availability, amount, and various options under the FCP may vary from year to year.

Eligibility

You are eligible for the FCP if you are (1) a regular active salaried employee, (2) a flexible service employee (see page 28), (3) a part-time employee (greater than 1/2 time), or (4) a graduate fellow. Your Delphi service date must be prior to January 1, 2001, you must be on the active salaried payroll as of December 31 of the preceding year in which the FCP is paid, AND you must be at work or on assignment six months or more of the preceding year in which the FCP is paid.

How FCP Works

For the 2001 Plan year, a full FCP equals $1,800 for each regular active salaried employee and $900 (or 50% FCP) for each part-time employee, or graduate fellow who meets the eligibility requirements.

The amount required to purchase additional days off and the number of days available for purchase will depend upon whether you qualify for a full FCP or a 50% FCP. If you are eligible for the full $1,800, you may purchase four additional days off for $600. However, if you are eligible for a 50% FCP, you may purchase two additional days off for $300. Installment payments either to your S-SPP or in your pay, will commence with the first pay of the year and conclude with the last pay of the year.

The FCP options are:

- $1,800/$900 as a lump sum payment (mid-March paycheck);
- $1,800/$900 deposited in your S-SPP account in 24 equal installments;
- $1,800/$900 paid in 24 equal installments to your pay;
- $1,200/$600 as a lump sum payment (mid-March paycheck) **plus** four/two additional days off;
- $1,200/$600 deposited in your S-SPP account in 24 equal installments, **plus** four/two additional days off;
- $1,200/$600 paid in 24 equal installments to your pay, **plus** four/two additional days off.

For the 2002 Plan year the FCP will not include the option of electing four additional days off or receiving $600. For the 2002 Plan year a full FCP equals $1,200 and all regular active employees will receive four additional vacation days. Delphi will communicate changes to this option in subsequent years.

Lump Sum Option

Under the lump sum option, payment of the (1) full FCP, (2) 50% FCP, or (3) amount remaining after purchasing the additional days off will be included in your mid-March paycheck. The FCP is subject to all federal, state and local income taxes and social security taxes; such taxes will be withheld from your paycheck.

Savings-Stock Purchase Program (S-SPP) Contribution Option

The FCP contribution option into your S-SPP account is made in equal installments effective with your first paycheck of the year. Your S-SPP deduction will include both your regular payroll contribution and your FCP contribution. Your FCP contribution into your S-SPP account will be on a pre-tax basis. If you reach any Internal Revenue Code (IRC) limit, any remaining FCP contributions to your S-SPP account will be made on an after-tax basis, to the extent permissible under federal tax law.

Furthermore, any FCP contributions and Incentive Compensation amounts contributed to your S-SPP account can be in addition to the maximum S-SPP contribution rate of 20% of your eligible salary.

Once your FCP is contributed to your S-SPP account, it becomes subject to all the rules and conditions of that Program — including the tax law requirements. FCP contributions to your S-SPP account will **not be eligible for Delphi matching contributions.** FCP contributions will be invested consistent with your current S-SPP investment election for your "discretionary contributions" (those contributions not required to be invested in the Delphi Common Stock Funds).

If you do not participate in the S-SPP but are eligible to do so, you may decide that the FCP option is a good way to start. **If you elect to deposit your FCP into the S-SPP but you do not have an S-SPP investment option election in effect,** your FCP contributions will be invested in the S-SPP Promark Income Fund.

If, as of December 31 of the preceding year in which the FCP is paid, you are not eligible to contribute to the S-SPP due to a suspension resulting from a hardship withdrawal, you **cannot** elect the option to contribute your FCP to the S-SPP. Furthermore, if you request and receive a hardship withdrawal from your S-SPP account after you had elected a FCP contribution to your S-SPP account, the FCP contribution to your S-SPP account would stop and the remaining amount would be added to your pay as installments for the remainder of the year.

Installment Option

The FCP installment option will commence with the first pay period in January and will conclude with the last pay period of the year. The FCP is an addition to your pay and is subject to all tax withholding.

Additional Days Off

The additional days off elected by you may be used (1) at any time during the year, **including the July shutdown period,** (2) after you have used your regular vacation entitlement, and (3) at a time that is mutually agreeable between you and your supervisor. Additional days off elected by you must be used during the calendar year. **There will be no payment for days unused at year end.**

Employment Status Changes

A change in your employment status during the year may impact your FCP. **If your status changes during the year,** you should keep the following points in mind.

- If you elect the lump sum option payment, it will be paid as a part of your mid-March paycheck — even if before that pay date you: (1) retire on February 1 or March 1, (2) are placed on an unpaid leave of absence, or (3) transfer to either hourly status or a Delphi subsidiary.

  No lump sum will be paid if your employment ends on or before the mid-March pay date **for reasons other than retirement.** Moreover, if you retire effective January 1, you are not eligible for FCP.

- If you elect installments to your pay or to your S-SPP account, they will cease as of the date your employment status changes. Any remaining balance would be paid either the later of your mid-March paycheck or after the date your employment status change is effective.

  However, **no remaining balance will be paid** if your employment ends during the year for reasons **other than retirement.**

- If you go on an approved leave of absence during the year and you are receiving salary continuation, installments to your pay or to your S-SPP account will continue.

- If you should die during the year, any lump sum payment and/or remaining balance of any installments will be paid to the Beneficiary of your Basic Life Insurance. These amounts will be paid with your mid-March paycheck or as soon as practicable thereafter.

Delphi Options!

The purpose of the Delphi Options! Program is to increase your flexibility regarding your total compensation as a Delphi salaried employee. It is designed to provide you with the opportunity to elect the benefit coverages that best fit the needs of you and your family. Thus, you determine what value you will receive from your personal benefits package. You also have the opportunity to increase your benefits or increase your pay along with the potential to realize significant tax advantages when you use the Program.

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Eligibility

Generally, you are eligible to participate in the Delphi Options! Program if you are:

- A regular active salaried employee (compensated on a monthly salary or salary plus commission basis);
- A Flexible Service employee
- Either of the above on certain leaves (for example, a disability leave of less than six months);

Benefits Affected

- Flexible Spending Accounts
  - — Health Care
  - — Dependent Care
- Salaried Health Care Program
  - — Medical
  - — Dental
- Life and Personal Accident Insurance
  - — Yourself
  - — Your spouse
  - — Your child(ren)
- Supplemental Extended Disability Benefits

Participation

Participation in the annual enrollment enables you to determine the type of benefit coverage you want based on your personal circumstances. You will enroll each fall for the following calendar year's coverage.

The choices you make generally become effective on January 1 of the following year and remain in effect through December 31 if you remain an eligible employee. However, if you elect to "opt out" or "waive" certain options, those elections will remain in effect for one or two years, as discussed on page 24. Additionally, any life insurance, Personal Accident Insurance, and Supplemental Extended Disability Benefits elections you make during the annual enrollment will become effective on the first day you are actively at work in the new Plan year.

You may change your elections, if you wish, during each annual enrollment period. However, you may change your elections during the year ***in the case of a "qualifying life event change."*** "Qualifying life event changes" are those the IRS considers to be a major change in your family situation. Some of the major events that may entitle you to change certain of your benefit elections during the year include the following:

- Certain changes in employment status for you or your spouse or an eligible dependent;
- Marriage or divorce;
- Addition of a dependent;
- Loss of a spouse or dependent;
- Retirement; and
- Relocation.

It is your responsibility to change your elections if you have a "life event change." You must notify the National Benefit Center within 31 days after a "life event change."

How the Program Works

Delphi provides you with "benefit dollars" to use. These "benefit dollars" are based on several factors including (1) the family status category you elect under your medical plan and (2) for life insurance, your annual base salary in effect as of September 1 preceding the Options! Plan year and your age as of December 31 of the Options! Plan year.

You may want to think of "benefit dollars" as the portion of Delphi's benefit budget under your control. You may use these benefit dollars to purchase benefits from the array of Options! coverages. Each coverage is assigned a price. You decide which coverage you want to elect — based on your personal or family needs — and simply total their prices.

- If you elect more benefit coverage than you have "benefit dollars," you pay for the difference from your salary.

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- If you have "benefit dollars" left over, you may elect additional coverages OR take the remaining "benefit dollars" as taxable income.

The following chart illustrates the current choices that may be available to you under the Options! Program.

Current Options!

Health Care and Dependent Care Spending Accounts (Refer to page 20 for further details)	■ Either account, both accounts or neither may be chosen ■ Annual contributions of $48 to $5,000, separate for each account

NOTE: Four different family statuses are available for each of the health care options described below. You may elect a different status for medical, dental, and vision. These categories are: you only; you and your spouse; you and your child(ren); you and your family (spouse and children).

Medical (Refer to page 31 for further details)	■ Basic Medical Plan (BMP) ■ Enhanced Medical Plan (EMP) ■ Point of Service (POS) ■ Preferred Provider Organizations (PPOs), where available ■ Health Maintenance Organizations (HMOs), where available ■ Opt out for non-Delphi coverage or no coverage ■ Waiver for other Delphi coverage
Dental (Refer to page 55 for further details)	■ Traditional Dental Plan ■ Alternative Dental Plans, where available ■ Opt out for non-Delphi coverage or no coverage ■ Waiver for other Delphi coverage (automatic when medical waived)
Vision (Refer to page 58 for further details)	■ Vision Plan ■ Opt out for non-Delphi coverage or no coverage ■ Waiver for other Delphi coverage (automatic when medical waived)

Supplemental Extended Disability Benefits (Supplemental Extended Disability Benefits) (Refer to page 77 for further details)	■ No coverage ■ Coverage (If on January 1 of the Plan year your credited service is at least six months but less than 10 years, this coverage may be elected.)
Life Insurance Options — for you (Refer to page 100 for further details)	■ One through seven times annual base salary (includes basic and Optional Life Insurance)
Dependent Life Insurance Options — for your spouse* (Refer to page 102 for further details)	No coverage $10,000 $25,000 $50,000 $75,000 $100,000
Dependent Life Insurance Options — for eligible children** (Refer to page 102 for further details)	No coverage $5,000 $10,000 $15,000

Personal Accident Insurance (PAI) Options – ■ **for you** ■ **your spouse** ■ **children** (Refer to page 103 for further details)	For you and your spouse**		For child(ren)**
	No coverage	$200,000	No coverage
	$10,000	$250,000	$10,000
	$25,000	$300,000	$20,000
	$50,000	$400,000***	$30,000
	$100,000	$500,000***	$40,000
			$50,000

* Texas state insurance law limits the amount of Dependent Life Insurance a Texas resident may have.
** Coverage for a spouse or child(ren) may not exceed coverage for you.
*** May not be elected if exceeds 10 times annual base salary.

Spending Accounts

Spending Accounts can save you money by allowing you to reimburse yourself for eligible expenses with pre-tax dollars you set aside through payroll deduction.

As a part of the enrollment process, you have the opportunity to establish health care and dependent care spending accounts:

- The health care spending account helps you pay certain health care expenses that are either not fully covered or not eligible for payment through your health care plans for you and/or your eligible dependents;
- The dependent care spending account enables you to reimburse yourself for eligible daycare and/or elder care expenses that may be necessary for you — and if you are married, your spouse — to be gainfully employed.

Spending Account Deposits

Deposits to your spending accounts come from pre-tax contributions from your pay. Spending accounts can save you money because your contributions to your accounts are ***not taxed,*** and they are not taxed when you reimburse yourself from the accounts. This means you do not pay federal, Social Security, state and local income taxes on the money you contribute. The result is a tax savings for you, which increases your disposable income throughout the year.

If you decide to establish a spending account, you may elect to contribute up to $5,000 each year in each spending account. Under current tax law, each year you must allocate a specific amount for each account. Each account has a separate maximum. And, federal regulations provide that you cannot switch amounts you have allocated to one spending account into the other.

Health Care Spending Account

Generally, almost any health care expense that is eligible for a deduction for federal income tax purposes may be eligible for reimbursement through your health care spending account. ***But a word of caution*** — you cannot do both. You may not deduct an eligible expense ***and*** receive reimbursement for that same expense. In addition, eligible expenses for reimbursement from your health care spending account include deductibles and copayments, but ***not the contribution or premium*** you pay for your health care coverage. This is because you are already paying for the cost of your Delphi coverage with pre-tax dollars.

The entire amount you elect to contribute to your health care spending account is available at any time — even if your current expenses exceed the amount deposited to your account to date. However, upon termination of employment, remaining contributions necessary to fulfill your annual election for the health care spending account will be taken from your final check, and if necessary, from any other monies which may become payable to you in the form of salary or benefits, as discussed on page 115. You will still be able to file claims for services received after termination and through the end of the calendar year. Claims for services incurred in a Plan year may be reimbursed through March 31 of the following year.

Your health care spending account may not be decreased or discontinued, even if you have a "life event change." Any monies that you do not use at the end of the year are forfeited.

Special Note

Remember, to receive reimbursement for your expenses the services must be
(1) eligible for reimbursement, and
(2) rendered during the year for which the spending account was established.

What Are Eligible Health Care Expenses For Reimbursement From The Spending Account?

Listed below are examples of eligible and non-eligible health care spending account expenses. **This is not intended to be a complete listing.** If you would like to receive additional information about eligible expenses, you should call the IRS at 1-800-TAX-FORM and request IRS publication #502 (Medical and Dental Expenses).

Eligible

- Medical, dental, and vision deductibles and copayments
- Prescription drug copayments
- Mental health and substance abuse copayments
- Allergy testing and treatment
- Noncovered orthodontic expenses
- Acupuncture
- Orthopedic shoes
- Prescribed birth control pills
- Organ donor expenses
- Special telephone equipment for the deaf
- Special equipment installed in your home or car for medical reasons
- Tutoring for certain learning disabilities
- Services of a Christian Science practitioner
- Special school costs for physically or mentally handicapped child(ren), including tutoring fees

Not Eligible

- Contributions and/or premiums for medical or dental coverage
- Marriage/family counseling fees
- Health care treatments, medicine, or services that are not legal
- Expenses for weight reduction or smoking cessation programs for general health purposes and unrelated to specific ailments
- Bottled water
- Cosmetics, sundries, and toiletries
- Cosmetic surgery (non-reconstructive)
- Vitamins, patent medicines, or tonics, even if prescribed by a physician
- Health programs offered by resorts, health clubs, or gyms
- Scientology fees
- Maternity clothes
- Domestic help (apart from nursing services), even if recommended by a doctor
- Hair treatments and medication to prevent hair loss, even if prescribed by a physician (for example, Rogaine)

Dependent Care Spending Account

The dependent care spending account allows you to reimburse yourself for dependent care expenses necessary for you — or you and your spouse — to be gainfully employed. If your spouse is disabled or a full-time student, you may also use this account. If you are married and file federal income taxes separately, your deposit to the dependent care spending account is limited to $2,500. If you file jointly, your maximum deposit to the account cannot exceed $5,000 or the smaller of your income or your spouse.

A word of caution:

- **Your monies not used at the end of the year are forfeited.**
- Your deposits to the **dependent care spending account** stop upon termination of employment. You will be able to file a claim for services received after that date up to your existing balance. Claims for services incurred in a Plan year may be reimbursed through March 31 of the following year.
- Your **dependent care claims** can be paid after service is rendered but only up to the balance available in your account at the time the claim is submitted. If your expenses exceed that amount, there will be a time lapse for reimbursement until sufficient funds are available in your account.

You should be aware that you cannot use the same expenses for both reimbursement from your dependent care spending account and claiming a federal dependent care tax credit.

Eligible dependents for your dependent care spending account include:

- Your dependent under age 13 whom you claim as a dependent for income tax purposes; and
- Any other dependent who isn't able to care for himself or herself.

Eligible expenses for the dependent care spending account may include care provided:

- In or out of your home;
- In an elder care center or a child care center that complies with all state and local regulations; or
- By a housekeeper whose services include, in part, care of an eligible dependent.

Special Note

Remember to receive reimbursement for your expenses, the services must be rendered during the year for which the spending account was established.

What Are Eligible Dependent Care Expenses For Reimbursement From The Spending Account?

Listed below are examples of eligible and ineligible dependent care spending account expenses. **This is not intended to be a complete listing.** If you would like to review additional information about eligible expenses, you should call the IRS at 1-800-TAX-FORM and request IRS publication #503 (Child and Dependent Care Expenses).

Eligible	*Not Eligible*
■ Baby-sitter expenses for care during your working hours inside or outside the home	■ Care provided by someone you claim as a dependent on your federal income tax return
■ Care provided by a housekeeper whose services include care of an eligible dependent	■ Expenses claimed under the federal dependent care tax credit for the calendar year
■ Licensed elder care center, child care center, and nursery school charges, if the facility complies with local, state, and federal regulations	■ Expenses incurred before participation
■ Social Security and other taxes you pay for an eligible dependent care provider	■ Overnight camp expenses
	■ Transportation to or from a dependent care provider
	■ Health care expenses for your dependents (may be eligible for health care spending account)

Requests for Reimbursement

You can obtain reimbursement claim forms through Apollo on the Benefits Home Page (in the forms section), or by calling the National Benefit Center (toll-free at 1-800-435-3946). Your requests for reimbursement are to be submitted to the claims paying administrator. Each request must be for at least $25, with a copy of your Explanation of Benefit statement or your paid receipt attached to the claim form, except that your last request at the end of each year may be for less. You will receive your reimbursement checks tax-free.

You have until March 31 of the following year to submit expenses for services rendered during the prior Plan year. Claims that are submitted after that time for a prior year ***cannot*** be reimbursed.

If you submit a reimbursement claim form and you are reimbursed for expenses that are not covered, or for more than should be allowed, federal law requires that such reimbursement is taxable income to you. You will be responsible for paying any tax required on those amounts.

Forfeitures

You should use the spending accounts ***only*** for eligible expenses that you can reasonably predict. That is because ***federal regulations require*** that **unused amounts** in each of your spending accounts at the end of each calendar **year must be forfeited.** Claims for services incurred in the calendar year may be reimbursed through March 31 of the following year. Any forfeited amounts will be used by Delphi to defray part of the administrative costs of the Program.

Planning to Use Spending Accounts

Getting the most out of your spending accounts takes some planning. Although there are tax advantages from using them, the tax laws — governing both personal taxes and benefits — may create confusion. The following chart summarizes the current tax rules as a reference tool for your use.

Summary of Flexible Spending Accounts (FSA) IRS Rules

Feature	Health Care Account	Dependent Care Account
Separate accounts	Accounts must be separate; you cannot move money from one account to another; you cannot receive reimbursement from one account for an expense covered by the other account.	
Tax-free	You do not pay Social Security, federal and most state or local income taxes on contributions and reimbursements.	
Alternative personal federal income tax treatment	FSA in lieu of health care itemized deductions	FSA in lieu of federal dependent care tax credit
Eligible expenses	Generally almost the same as those qualifying as itemized deductions, **except premiums and/or contributions.** Remember, services must be rendered within that Plan year.	Dependent care expenses necessary for you or your spouse to work (or your spouse to attend school full-time). Remember, services must be rendered within that Plan year.
Eligible dependent	Dependent claimed for federal income tax purposes.	Your child(ren) under age 13; a dependent parent; a dependent or spouse unable to care for himself/herself.
Pre-paid care ineligible	Services for eligible expenses must be received during the calendar year; pre-paid care or services to be received during the previous or following calendar year do not qualify for reimbursement. (e.g. orthodontia)	
Contribution maximums*	$5,000	$5,000 if you are a single parent or married filing jointly $2,500/person, if married and filing taxes separately The lesser of your income or your spouse's income
Sources of contributions	Pre-tax deductions from your pay	
Reimbursement availability	**Up to annual contribution at any time**	Up to amount accumulated in your account
Unused balance	**Money not used for reimbursement of expenses will be forfeited after March 31 of the following Plan year**	

** Delphi requires a $48 minimum annual contribution to establish a spending account.*

Other Options! Benefit Considerations

Effect on Other Benefits

Although your pre-tax contributions will lower your pay for certain tax purposes, they will not lower your pay for determining pay-related Delphi benefits such as:

- Retirement benefits;
- S-SPP contributions;
- Basic and Optional Life Insurance amounts; or
- Disability benefits.

Participation in the Delphi Options! Program may have some effect on your Social Security benefit at retirement. Under the Program, you do not pay Social Security taxes on any pre-tax contributions from your pay. That means if your taxable income is less than the maximum Social Security wage base, your future benefits, which are based on the Social Security taxes you pay, could be somewhat less than if you did not elect to authorize pre-tax contributions from your pay.

Participation in the Delphi Options! Program will not affect contributions to your S-SPP account.

Opt Outs

You may elect to forego any or all medical, dental or vision plan coverages from Delphi and receive "opt-out dollars" in lieu of coverage. If you elect to opt out of only one of these coverages, you remain eligible for the other. Additionally, if you opt out of any coverage, certain restrictions will apply if you want that coverage later. If you opt out of medical coverages, this election will remain in effect for one calendar year, while opt outs for dental coverage remain in effect for two calendar years. For example, if you opt out of your dental coverage, ***you must wait two years*** before you will be permitted to elect coverage again.

Because an opt out is an election to receive opt-out dollars in lieu of coverage for the period you opt out, you ***cannot be carried as a dependent on another person's Delphi coverage.*** The opt-out dollar value will be established each year.

You may not opt out if you are ordered to provide coverage pursuant to a Qualified Medical Child Support Order.

Waivers

When you and your spouse are both employed by Delphi and each of you can elect coverage in your own right, you may ***"waive"*** coverage to be covered as a dependent of your Delphi spouse. When ***you waive medical coverage you automatically waive dental and vision coverage*** although you may be enrolled for these coverages as your spouse's dependent. Because you will still receive medical, dental and vision coverage through Delphi, you will not receive opt-out dollars under the Program. You will be eligible to elect medical, dental and vision coverages again depending on which Delphi plan covers you as a dependent during the waiver period.

You may not waive coverage if you are ordered to provide coverage pursuant to a Qualified Medical Child Support Order.

Proof of Good Health

If you experience a qualifying life event change and wish to modify your elections, during the same year, contact the National Benefit Center within 31 days of the event. In some cases, you may be asked to provide satisfactory proof of good health.

Changes in Employment Status

If you (1) retire, (2) die, (3) become disabled, or (4) employment is terminated, you will forfeit any unpaid cash payment due you for any unused opt-out dollars. In addition, if you were contributing to a spending account prior to any such change in status, you may receive reimbursement (1) up to your elected annual account balance for eligible health care services rendered any time during the Plan year and/or (2) up to your year-to-date dependent care spending account balance for eligible dependent care expenses, as may be applicable.

Note: The health care spending account deduction from your last pay check will equal the amount needed to fulfill your elected annual contribution.

You will forfeit any amount remaining in one or more of your spending accounts after March 31 of the following Plan year.

Administration

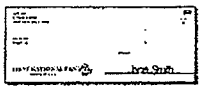
Any election, status change, or questions in general pertaining to the Delphi Options! Program should be directed to the National Benefit Center at the following toll-free number: ***1-800-435-3946.***

A Word About Taxes

Pre-tax, after-tax, tax free... what do they mean? Do they apply to you? How do they affect your benefits? All are valid questions. The Program offers benefit options that are available on either a pre-tax or an after-tax basis. *Your **pre-tax options*** include medical and dental plans (except for coverage of non-dependent domestic partners), health and dependent care spending accounts, and Supplemental Extended Disability Benefits. ***Pre-tax options*** are purchased with contributions taken from your pay before both income and Social Security taxes are calculated and withheld.

Note: By paying for benefits with pre-tax dollars, you lower your taxable income.

Your ***after-tax options*** include the portion of any employee life insurance coverage in excess of Basic Life Insurance, any Dependent Life Insurance coverage for your spouse and child(ren) and all Personal Accident Insurance, as well as medical and dental coverage for a non-dependent domestic partner. ***After-tax options*** are paid for with deductions taken from your pay ***after*** taxes are calculated and withheld.



	The Formula	Description
	Gross pay	**Gross pay** is your pay for the current pay period.
-	**Pre-tax elections**	Before taxes (Social Security, federal, state, and local income taxes) are deducted from your pay, the total of any of your **pre-tax benefit elections** are subtracted from your pay.
=	**Pre-tax net pay**	The result: your **pre-tax net pay** is a lower amount of taxable income.
-	**Taxes**	Social Security, federal, state and local taxes
-	**After-tax elections**	The total of any of your **after-tax benefit elections** are deducted from your **pre-tax net pay.**
=	**Net pay**	This gives you your take-home or **net pay.**

How It Works

- **Each pay period:**
  - Certain **pre-tax** elections are deducted
    - Medical and dental coverage
    - Health and dependent care spending accounts
- **Mid-month pay period:**
  - **Pre-tax** elections for Supplemental Extended Disability Benefits is deducted
  - Your **after-tax** elections are deducted
    - Optional Life Insurance
    - Dependent Life Insurance
    - Personal Accident Insurance

If You Have Health Care Expenses

The Delphi Automotive Systems Salaried Health Care Program (SHCP) provides comprehensive coverage for you and your eligible dependents for a wide range of health care services and expenses including acute care services (such as surgery and hospitalizations) and preventive care (such as physicals and physician office visits). There also are components covering long-term and custodial care needs. The Program helps protect you from catastrophic medical costs while allowing flexibility in the way you plan for your health care expenses.

The specific provisions of the SHCP, the range of covered services, eligibility rules and so forth may be amended, modified, suspended, increased, decreased or terminated by Delphi from time to time through the years. Additionally, while coverages provided under this Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances, nor is it intended to do so. You should seek guidance from your health care Carrier if you have questions about whether a particular health care service or expense is covered under the Program. The following information is based upon the Program provisions as of January 2000, unless otherwise noted.

Basic hospital, surgical, medical, prescription drug, hearing aid, mental health, substance abuse and extended care coverages are known as "core coverages." Dental and vision coverages also are provided and are known as "non-core coverages."

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Eligibility for Coverage...

You

Generally, you are eligible for health care coverage if you are:

- A regular active salaried employee (compensated on a monthly salary);
- A Flexible Service employee;
- A part-time employee, qualifying for benefit plan coverage;
- Either of the above on certain leaves (for example, a disability leave of less than six months).

You are eligible for coverage on the first day of the third month following the month of hire, provided you are actively at work on that day. For example, an employee hired January 16 would be eligible for coverage April 1. If you are not in active service on the date your health care coverages otherwise would start, your coverages become effective upon your return to work.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may in the future be able to enroll yourself or your dependents in the Salaried Health Care Program, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent (e.g., as a result of marriage, birth, adoption or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the event.

If Your Status Is...

- **Expatriate Personnel** You are eligible for the coverage provided under the International Health Care Plan which consists of hospital, surgical, prescription drug, hearing aid, mental health and substance abuse, dental, and vision coverages and the optional Comprehensive Medical Expense Program (CMEP). **This excludes Extended Care Coverage (ECC).**
- **Flexible Service Employees**
  You may select options other than the Basic Medical Plan, but you will be required to pay an additional $50 per month employee contribution. Effective January 1, 2002, the additional $50 per month employee contribution has been eliminated. You are also eligible for Extended Care Coverage (ECC).
- **Cooperative Students**
  If your service date is prior to January 1, 1999, you are eligible for the ***core coverages only under the Basic Medical Plan**** as outlined on page 31. You are **not** eligible for dental, vision and Extended Care Coverages (ECC). If your service date is on or after January 1, 1999, you are not eligible for coverage.

  **As a Cooperative Student, you will automatically be enrolled in the coverages as outlined above, unless you contact the National Benefit Center to request a waiver of coverages.*

Your Dependents

Some of your dependent family members may be enrolled for coverage with Corporation contributions while for others you must pay the full cost of coverage.

Eligible family members that may be enrolled for coverage with Corporation contributions may include:

- Your spouse;
- Your natural or adopted children;

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- Your current spouse's natural or adopted children,
- Your same-sex domestic partner; and
- Your domestic partner's children — if they qualify as your dependents.

You should note that a spouse or children acquired after retirement can be enrolled only as a sponsored dependent, as described later in this section. Same-sex domestic partners and their children acquired after retirement are not eligible for coverage.

To be eligible for Program coverage with Corporation contributions children must meet certain tests. These tests include:

- **Relationship:** The children must be yours or your current spouse's by birth or legal adoption.
- **Age:** The children must not have reached the end of the calendar year in which they turn age 19, except for two cases:
  - The first is if the children are ***full-time students*** for at least one full school term during the calendar year, in which case they remain eligible for such year(s), ***but not beyond the end of the calendar year in which they turn age 25.*** Such children, age 24 or older, must qualify as your dependents under Section 152 of the Internal Revenue Code.
  - The second exception is the case of ***totally and permanently disabled (T&PD)*** **child(ren)**. T&PD children may have coverage continued if they continuously meet the SHCP's definition of T&PD status (i.e., having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration) and continue to meet all other applicable eligibility requirements.
- **Marital status:** The children must not be married.
- **Residency:** The children must reside with **you** (a children temporarily away from home while attending school full time, meets this test) or **you** must have legal responsibility for the provision of health care coverage. If you are ordered to provide coverage for your children pursuant to a divorce decree, court order, paternity order or a qualified medical child support order (QMCSO) as defined by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), you may be able to satisfy the residency test for children that do not reside with you.

Same-Sex Domestic Partners and Their Children

Effective January 1, 2001 the eligibility provisions of the Delphi SHCP were expanded to permit enrollment of qualified same-sex domestic partners and their eligible children.

To qualify for coverage, you and your domestic partner must:

- Be the same sex;
- Have shared a continuous committed relationship for at least six months, intend to do so indefinitely and have no such domestic partner relationship with any other person;
- Reside in the same household;
- Share responsibility for each other's welfare and financial obligations;
- Not be related by blood to a degree of kinship that would prevent marriage from being recognized under law;
- Be over age 18, of legal age and legally competent to enter a contract;
- Reside in a state where marriage between two persons of the same sex is not recognized as valid under law; and
- Not be married to any other person.

In areas where marriage is legal for same-sex couples, marriage is required for eligibility. Similarly, if a state has some formal recognition of a domestic partner relationship (for example, the "Civil Union" in Vermont), recognition under such state law is required.

Your domestic partner's children are eligible for enrollment only if ***you***, as primary enrollee, are eligible to claim exemptions for them on your federal income tax return. The domestic partner's children must also satisfy the general eligibility rules for children.

Generally, employees enrolling domestic partners have the standard plan options. However, certain insured managed care entities may not accept domestic partners. If the plan in which you are enrolled at the time you add a domestic partner does not accept them, you may change options, subject to administrative rules.

Although retirees may not add new domestic partners or their children to coverage after retirement, they may continue coverage for eligible domestic partners or their children who are enrolled at the time of retirement.

Under current federal and most state tax laws, unless you, as the employee, can legally claim an exemption for the partner on your tax return, the partner is not entitled to the same tax treatment as if you were adding a spouse. Consequently, the value of the health care coverage represents imputed income to you. In addition, any contributions required for the domestic partner's coverage are to be made on a post-tax basis.

Under current federal law, a domestic partner does not qualify for COBRA continuation. However, if you and your partner terminate the relationship, an option to continue coverage, on a basis comparable to COBRA, will be available. In the event of your death, a surviving domestic partner will be provided continuation opportunities comparable to a similarly situated surviving spouse.

Sponsored Dependents

You also may be able to enroll certain individuals for limited Delphi medical coverage as a sponsored dependent if you are **able to, and do, legally claim them as exemptions on your federal income tax return.** You pay the full cost of such coverage. The following individuals may be enrolled for sponsored dependent coverage:

- Your child or your current spouse's child who:
  - — is single,
  - — lives with you, and
  - — does not satisfy the age test;
- Minor child(ren) living with you and for whom either you or your current spouse is the court-appointed guardian because both natural parents of the minor child(ren) are deceased;
- Minor child(ren) living with you and who is the child(ren) of one of your enrolled dependent child(ren);
- One or both of your parents or your current spouse's parents; or
- A spouse and/or child(ren) acquired after retirement.

Before becoming eligible for coverage, sponsored dependents who are not citizens of the United States must reside in the United States for one full year and must be legally entitled to remain in the United States indefinitely. The medical coverage available to sponsored dependents is the same option you choose for yourself. Each sponsored dependent has his or her own set of contributions, deductibles, copayments, and out-of-pocket maximums, if applicable. Coverage is effective the first of the month following receipt of a completed application and any necessary supporting documentation.

You may not purchase dental, vision or Extended Care Coverage (ECC) for sponsored dependents.

Medical Plan

Periodically, U.S.-based regular salaried employees will be provided an opportunity to elect coverages through the medical plan options available under the SHCP. Such elections also may include a choice among dental options. Separate provisions apply to U.S. regular salaried employees residing in Canada (see page 68), and salaried employees classified as Expatriate (see page 28).

The specific choices available will depend on your status, the availability of approved options in your geographic area, and you and/or your eligible dependents' Medicare status. Additionally, you may be required to make monthly contributions for coverages, as determined annually, according to your status, enrollment classification, option elected, the type and number of dependents enrolled, and Medicare status.

You may elect from among five types of medical plan options and certain alternative dental plan options to the extent such options are available in your area. From time to time, the types of available options may change. The current types of Medical Plan options are as follows:

- The Basic Medical Plan (BMP) option;
- The Enhanced Medical Plan (EMP) option;
- The Preferred Provider Organization (PPO) option;
- The Point of Service (POS) option; and
- The Health Maintenance Organization (HMO) option.

These options are designed to provide quality care on a cost-effective basis. Descriptive materials concerning benefits provided under each option are available from the National Benefit Center.

In general, covered expenses and major limitations and exclusions are summarized below. ***This is a general description only and the provisions of the SHCP control your eligibility for coverage and specific benefits.*** Furthermore, each HMO has its own rules that should be obtained from the HMO. A glossary of terms is provided at the end of the handbook. Also provided on page 36 is a chart intended as an at-a-glance resource.

Under the Basic Medical Plan, the Enhanced Medical Plan, the Preferred Provider Organization, and the Point of Service Plan selected Carriers handle certain administration and claims processing for the Delphi programs. Under the Health Maintenance Organization option, coverages are provided by HMOs for which Delphi contributes for the premiums. The individual HMOs are solely responsible for financing, administration, medical policy, claims processing, and appeal procedures.

Basic Medical Plan (BMP)

If you enroll in the BMP option for core coverages, currently you will not be required to make a monthly contribution. However, you will be required to share a part of the expense of covered services.

- An annual $900 individual or $1,800 family deductible will be applied to covered services (other than certain screening tests/examinations, durable medical equipment and prosthetic and orthotic appliances, prescription drugs, mental health, substance abuse, and extended care services, as discussed in a later section). Only the reasonable and customary charges for covered services can be counted toward meeting the deductible. Each covered individual can contribute only a maximum of $900 toward satisfying the family deductible.

- After the annual deductible is met, you will be responsible for a 25% copayment for most covered services, until your annual out-of-pocket expense for such copayment equals a maximum of $1,600 for an individual or $3,200 for a family. Your maximum annual out-of-pocket expense for the deductible and copayment for covered services is limited to $2,500 ($900 individual deductible plus $1,600 copayment) for an individual and $5,000 ($1,800 family deductible plus $3,200 copayment) for a family.
  After your maximum annual out-of-pocket expense is reached, charges for any remaining covered services will be paid at 100% of the reasonable and customary amount for the rest of the year.

- Prescription drug, mental health and substance abuse, certain routine screenings and extended care coverages are not subject to the deductibles and copayments noted above. Charges incurred for prescription drug, mental health and substance abuse treatment, and extended care services will not be counted toward satisfying the deductible or out-of-pocket maximum.

The BMP, EMP and PPO options have a number of specialty administrators that are responsible for a very specific portion of the health care program. By using specialty or "carve out" programs, Delphi is able to access specialty networks with credentialed providers, quality and service performance requirements, and improved pricing. Currently these specialty administrators include:

- Merck-Medco Managed Care for prescription drug coverage administration,

- CIGNA Behavioral Health for Mental Health/Substance Abuse coverage administration,

- Northwood NPN for Durable Medical Equipment and Prosthetic and Orthotics, and

- Health International is Medical Management Administrator for non-Medicare enrollees.

Medical Management Administration consists of three features: Care Management, Disease Management, and Centers of Excellence.

The ***Care Management*** feature requires advance review of any hospital stay (except emergency or maternity), inpatient and outpatient surgery (with the exception of surgical procedures performed in a doctor's office), skilled nursing facility admission or home health care visit. Nurses and board-certified physicians from our Care Management administrator, Health International, advise, educate and present alternatives that help enable patients to make informed decisions about the treatment that's best for them. ***Enrollees are responsible for assuring that Health International is called regarding procedures that require predetermination.*** If a procedure is determined not to be covered under the Program, the provider and enrollee will receive communication regarding its non-covered status.

If you do not call, or if you proceed with services that are considered medically inappropriate, you will be responsible for up to an additional $200 per occurrence for services provided. These amounts (up to $600 per year) are in addition to any normal deductibles and copayments, and will not be applied to your out-of-pocket maximum.

Predetermination is not a guarantee of benefit payment. To be covered, the service must meet all terms and conditions of the Program.

The ***Disease Management*** feature is a confidential, voluntary resource if you have a serious, chronic condition, such as asthma, diabetes or heart disease. Medical professionals who specialize in these conditions work with you and your doctor to develop a personalized, coordinated plan of care.

Centers of Excellence is a confidential, voluntary resource that provides you with information about and access to doctors, hospitals and health centers that are nationally recognized for improved outcomes in treating specific conditions. Financial assistance may also be provided if you and a family member need to travel to a Center over 100 miles from your home. When travel to a Center of Excellence is approved by Health International, travel expenses of up to $7,500 may be reimbursed through procedures that have been established by the administrator.

Questions regarding the Care Management, Disease Management and Centers of Excellence features may be directed to Health International at 1-877-405-0134.

Enhanced Medical Plan (EMP)

The features of the EMP option are the same as those of the BMP option previously described except:

- A monthly contribution is required for core coverages;
- The annual deductible amounts are $300 and $600 for an individual and a family, respectively;
- The copayment rate for expenses incurred above the deductible is 20% for a maximum annual amount of $1,000 for an individual and $2,000 for a family; and
- The total annual out-of-pocket maximum for deductible and copayments for covered services is $1,300 and $2,600 for an individual and a family, respectively.

EMP has specialty providers for prescription drug coverage, mental health/substance abuse coverage, DME/P&O coverage, and medical management. See the appropriate section for more information. Details regarding the Care Management, Disease management and Centers of Excellence features are described under the section on BMP.

The Preferred Provider Organization (PPO)

Under this health care arrangement, selected physicians, hospitals, and other health care providers in a geographic area are pooled together as a network to provide services to you and your family. You may be required to pay a monthly contribution for enrollment in the PPO option.

- When PPO network providers are used and all PPO network rules (e.g., required referrals) are followed, core coverages (other than certain screening tests/examinations, prescription drugs, mental health, substance abuse, and extended care services) are subject to a 10% copayment, up to a calendar year maximum out-of-pocket cost for covered services of $1,300 for an individual and $2,600 for a family.
- If you choose to go to a non-PPO network provider (unless referred by a PPO panel provider or in the event of an emergency), payment for covered services will be 70% of the PPO's level of payment for the same service or, if less, 70% of the actual charge. You will be responsible for the difference between the PPO's payment and the non-panel provider's charge. The amount of your liability will **not** be applied to the $1,300 individual or $2,600 family out-of-pocket maximum.

PPO has specialty providers for prescription drug coverage, mental health/substance abuse coverage, DME/P&O coverage, and medical management. See the appropriate section for more information. Details regarding the Care Management, Disease management and Centers of Excellence features are described under the section on BMP.

The Health Maintenance Organization (HMO)

Health Maintenance Organizations (HMOs) are health care delivery systems or organizations that emphasize preventive health care and early treatment, as well as provide medically necessary care for illness and injury. HMO coverage differs from the BMP and EMP options in that you must receive services from HMO providers for the services to be covered. Unlike the PPO and POS option, non-emergency services obtained from providers outside of the HMO panel are **not** covered at all unless the primary care physician makes the referral or the HMO authorizes treatment.

HMOs have monitoring systems to assess quality of care, necessity of treatment, and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you.

If you are enrolled in an HMO option, all of your core coverages are provided by the HMO except Extended Care Coverage. ***Coverage for services may vary from that provided under the BMP, EMP, POS and PPO options.*** Therefore, it is important to review the HMO enrollment materials carefully to become familiar with the scope and level of benefits that are available through a particular HMO. Detailed information about coverage can be obtained directly from the HMO.

HMOs are offered based on your address of record. You should contact the National Benefit Center to obtain information regarding the HMOs available to you. Additional literature can be obtained by contacting an HMO and requesting the membership handbook that describes its benefits and the provider directory which lists the doctors, hospitals, laboratories, and pharmacies that participate in that HMO. **If you are considering enrollment in an HMO, you should carefully review the HMO's provider directory or contact the HMO to understand provider availability in your area.**

The individual HMOs are solely responsible for administration, claims processing and appeal procedures.

The Point of Service Option (POS)

Under the POS plans, selected physicians, hospitals, and other health care providers in a geographic area have been contracted as a comprehensive network to provide covered services to you and your eligible family members.

Generally, covered services in the POS are the same as the covered services provided under the BMP, EMP and PPO, Delphi's other self-insured options. Although, a POS may offer certain benefit enhancements, such as allergy testing and injections, the key differences are the cost-sharing design and the managed care features built into the POS. Each POS requires every enrollee to select a Primary Care Physician (PCP) and each POS has administrative practices in place to ensure that your care is coordinated. In order to maximize the value of the POS plan, it is important to understand and follow the practices outlined in the materials provided by the POS.

The Delphi POS option for prescription drug coverage is administered by Merck-Medco Managed Care.

There are several key characteristics that define the Delphi POS arrangement.

Physician Centered Patient Management

Similar to an HMO, every enrollee must select or be assigned to a PCP. The PCP is responsible for coordinating all of your care. By using your PCP, you can ensure that your care is fully coordinated to maximize your health potential. At the same time, you can maximize the scope and level of benefits available by receiving your care within the POS through your PCP.

Simple Cost Sharing Design

All of the cost sharing within the POS option is based on flat dollar copayments so that you always know what a covered service will cost if received in the POS through your PCP. As of January 1, 2001, the copayments are as follows:

Office visit and outpatient services	$15.00
Emergency room (waived if admitted)	$50.00
Outpatient surgery (facility charge)	$100.00
Inpatient stay (facility charge)	$300.00

These copayments will be reviewed from time to time, and you will be advised if there is a change.

Freedom to Receive Certain Services Out-of-Network

Unlike an HMO, you can choose to receive certain covered services without a PCP referral. Although, you have the freedom to go out of the POS network, there are several important items to remember:

- Some services are not covered if they are received out of the POS network.
  - This limitation includes allergy treatments, home health care, durable medical equipment, prosthetic and orthotic appliances, most mental health services, treatment for alcohol and drug abuse, and hearing aid services.

- Furthermore, any service generating a facility charge, such as an inpatient stay or an outpatient surgical procedure performed in a hospital or freestanding surgical center still requires predetermination by the POS Carrier for medical necessity and length of stay.

- Services received outside the POS network have a cost-sharing structure similar to the EMP.
  - There will be an annual $350 individual deductible or a $700 family deductible applied to most covered services.
  - In addition to the deductible, there is an employee coinsurance of 20%. This means that after the annual deductible is met, payment for out-of-network covered services will be 80% of the reasonable and customary (R&C) amount as determined by the Carrier or, if less, 80% of the actual charge. You will be responsible for the difference between the Carrier's payment and the out-of-network charges.
  - The out-of-pocket maximum for out-of-network services is $2,000 for an individual and $4,000 for family. Out-of-network deductibles and coinsurance for covered services are applicable with the exception of prescription drug, mental health substance abuse, and dental coverage. Charges in excess of the Carrier's R&C are not applicable toward the out-of-pocket maximum. In-network copayments are also not applicable.

A monthly contribution is required if you elect the POS option.

HMO, BMP, EMP, POS and PPO Employee Cost Sharing At-a-Glance

	HMO	BMP (1)	EMP(1)	POS		PPO	
				In-Network (1)	Out-Of-Network (2)	In-Network (1)	Out-Of-Network (2)
Monthly contributions	Yes	None	Yes	Yes	Yes	Yes	Yes
Annual deductible:							
Individual	None	$900	$300	None	$350	None	None
Family	None	$1,800	$600	None	$700	None	None
Coinsurance: (3)							
Plan pays	100%	75%	80%	100%	80%	90%	70%
You pay	0%	25%	20%	0%	20%	10%	30%
Copayments (4)	Yes	No	No	Yes	No	No	No
Out-of-pocket maximum: (5)							
Individual	None	$2,500	$1,300	None	$2,000	$1,300	None
Family	None	$5,000	$2,600	None	$4,000	$2,600	None

(1) Annual deductibles, copayments, and out-of-pocket maximums are calculated on the basis of "Reasonable and Customary" (R&C) charges as determined by the Carrier. For PPOs, POS, BMP and EMP in the case of those Carriers with "participating" or approved provider arrangements, it is the amount the participating/approved provider has agreed to accept for covered services.

(2) Except in the case of a bona fide medical emergency, if you use a provider other than your Primary Care Physician without the proper preauthorization, the plan will pay the out-of-network coinsurance amount on the lesser of the charge or the Plan's fee schedule, and you will pay the rest.

(3) The amount paid for out-of-network services in the POS and PPO plans are based on the in-network fee schedule. The remaining balance is the responsibility of the enrollee.

(4) Copayments are specific amounts paid by the enrollee for a specified covered service. The amount varies depending on the covered service.

(5) Deductibles, copayments, and out-of-pocket maximums apply only to covered hospital, surgical, and medical services. The out-of-pocket maximum does not apply to mental health/substance abuse coverage. There are separate cost-sharing features for prescription drug and dental coverages.

Medical Plan Coverages

The various medical plan coverages described in this section apply to the BMP, EMP, POS and PPO options. Health International (HI) is the utilization review organization for the BMP, EMP and PPO options regardless of the Carrier. For these options, HI performs all predeterminations for inpatient admissions, outpatient surgeries, skilled nursing facility admissions, and home health care services. POS plans perform their own utilization review within the Plan. As previously noted, medical coverages available under HMO options may vary from those described below.

Hospital

What Is Covered

In general, for an inpatient stay to be eligible for full plan coverage, it must be: (1) medically necessary, (2) prescribed by your doctor, and (3) "predetermined" by the Carrier, as to the setting and length of stay. ***(Note: Predetermination is not a guarantee of payment.)***

Your doctor may order surgery, tests, or treatment that do not require an overnight stay. When you or a dependent receive covered services from an outpatient department of a hospital, the hospital's facility charges are generally covered on the same basis as inpatient care. Facility charges also may be covered for services performed in an ***approved*** free-standing ambulatory surgery facility. For certain outpatient procedures (such as surgeries), predetermination is required before the procedure is performed.

Facility charges covered under hospital coverage (maximum of 365 days per "benefit period," 45 days in the case of tuberculosis) include, but are not necessarily limited to:

- Semiprivate room, general nursing services, meals and special diets;
- Private room accommodations, if medically necessary;
- Use of operating rooms;
- Anesthesia when administered by an employee of the hospital and anesthesia supplies, gases, and use of equipment;
- Laboratory and pathology examinations under the direction of the hospital's pathologist;
- Chemotherapy (chemotherapeutics, antineoplastic agents, and select ancillary drugs and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is (1) research, (2) investigational, or (3) experimental in nature;
- Physical, functional occupational, and speech therapy;
- Oxygen and other gas therapy;
- Drugs, biologicals and solutions, and other supplies used in treatment while in the hospital;
- Supplies and equipment used during hospital stays including:
  - Supplies for dressings and casts (gauze, cotton, fabrics, solutions, plaster, and splints);
  - Durable Medical Equipment (DME); and
  - Prosthetic and Orthotic (P&O) appliances;
- Maternity care and routine nursery care; (generally, under federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods);

- Hospital service in a special care unit;
- Blood services, including transfusions of whole blood and packed red blood cells (if not replaced);
- Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment and which has a hemodialysis program approved by the Carrier;
- Necessary and appropriate x-rays;
- Pulmonary function evaluation;
- Tissue storage bank costs (e.g., skin banks and bone banks) for inpatients only; and
- Emergency room services and observation care (see the glossary for definition and further description of terms and conditions).

What Is Not Covered

Limitations and exclusions to the hospital coverage include, but are not necessarily limited to, the items listed below:

- Drugs, biologicals and solutions — beyond the extent they are used in connection with the inpatient or outpatient service;
- Chemotherapy done on a research, investigational or experimental basis (as determined by the Carrier);
- Outpatient treatment of chronic conditions that require repeated hospital visits (except hemodialysis and IV infusion therapy services);
- Follow-up care in an emergency room for treatment received initially in an emergency room (follow-up should be done in a physician's office to avoid facility charges);
- Hyperbaric oxygenation provided to treat a chronic condition;
- Skin bank, bone bank, and other tissue bank services for outpatients, (except for certain specified procedures);
- Hospital admissions and services beyond the period which is medically necessary for the proper care and treatment of the patient, or in excess of the maximum benefit period (see glossary for definition) or inconsistent with other applicable Program provisions;
- Hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care;
- Hospital services consisting principally of dental treatment or extraction of teeth (except when either multiple extractions or the removal of one or more unerupted teeth is performed under general anesthesia and a concurrent hazardous medical condition exists);
- Inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational, or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication or environmental control;
- Facility charges for care received in an urgent care center;
- Facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the Carrier;
- Facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting, or similar surgical procedures to correct vision), sterilization reversals, or non-covered plastic, cosmetic, or reconstructive surgery.

Skilled Nursing Facility

In some cases, the patient's condition may necessitate care in a facility but not require the extensive services available in a hospital setting. Services received from skilled nursing facilities licensed to provide such care may be covered under your Delphi medical plan. ***When such services are recommended, they must be predetermined by the Carrier prior to the admission, to determine if such services are covered by the SHCP and to ensure that the intended provider of such services is approved by the Carrier. You should call or ask your doctor, the hospital and/or discharge planning staff or the skilled nursing facility staff to make the call to predetermine these services.***

The Carrier can also determine whether the patient is a candidate for case management and work with the Extended Care Coverage (ECC) Carrier and the DME and P&O Network in appropriate cases.

What Is Covered

Two days of inpatient skilled nursing facility care are available for each remaining day of inpatient hospital care within the benefit period (see glossary for definition), up to a maximum of 730 days for each continuous period of confinement. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. The use of skilled nursing facility days does not reduce the number of days of inpatient hospital care available.

For skilled nursing facility care to be covered it must be:

- Prescribed by a physician;
- Medically necessary based on the severity of illness/injury and intensity of the service;
- Received from a Carrier-approved skilled nursing care facility; and
- Provided and billed by the facility.

Services provided under skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Semiprivate room and board;
- Meals and special diets;
- General nursing services;
- Use of special treatment rooms;
- Routine laboratory exams;
- Physical, functional occupational, and speech therapy, when medically necessary;
- Oxygen and other gas therapy;
- Drugs, biologicals and solutions used while in the facility;
- Supplies for dressings and casts; and
- Durable Medical Equipment (DME).

What Is Not Covered

Services not covered under the skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Care that is principally custodial or domiciliary in nature (although coverage may be available under ECC); and
- Treatment for tuberculosis or substance abuse.

Physical, Functional Occupational and Speech Therapy, and Cardiac Rehabilitation

When you or a family member require certain therapies to restore or improve musculoskeletal, speech, or cardiac performance, your health care program may provide coverage to help you meet these needs.

Outpatient services must be (1) approved by the Carrier, (2) prescribed by the physician in charge of the case, (3) provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational, or speech therapist for the specific therapy prescribed, and (4) billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility, or independent therapist approved by the Carrier.

What Is Covered

Services provided under physical, functional occupational, speech therapy, and cardiac rehabilitation coverage include, but are not necessarily limited to, the items below:

- Medically necessary physical, functional occupational, speech therapy, and cardiac rehabilitation:
  - During a covered admission to a hospital or skilled nursing facility for the treatment of the condition for which the patient is admitted. These services normally are billed by the hospital or skilled nursing facility;
  - Care prescribed and received through an approved rehabilitation center that meets SHCP standards;
- Physical, functional occupational, and speech therapy provided through an approved home health care agency;
- Outpatient physical and functional occupational therapy to restore or improve musculoskeletal function;
- Restorative speech therapy on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness, subject to certain limitations; and
- Cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician (limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris, or certain heart surgeries).

What Is Not Covered

Services not covered under the physical, functional occupational, and speech therapy and cardiac rehabilitation provisions include, but are not necessarily limited to, the following:

- Speech therapy for:
  - Educational learning disabilities;
  - Deviant swallow or tongue thrust;
  - Mild developmental speech or language disorders;
  - Congenital deafness;
  - Elimination of a lisp, or similar defect in articulation;
  - Improving speech that is not fully developed; or
  - Long-standing, chronic conditions or inherited speech abnormalities except:
    - When the patient is diagnosed as having a severe communication deficit as defined by Program standards; and when speech therapy is not available through other public agencies (i.e., state or school);
- Physical and functional occupational therapy when:
  - The condition is not expected to improve in a reasonable and generally predictable period of time;
  - Improvement does not occur, as documented in the patient's record on a periodic basis; or
  - Progress is no longer being made or the previous level of function has been restored;
- Physical and/or functional occupational therapy provided solely to maintain musculoskeletal function;
- Inpatient admissions which are principally for physical, functional occupational, and/or speech therapy or cardiac rehabilitation;
- Manipulation, adjustment, or massage of the musculoskeletal system;
- Vision therapy or training;
- Cognitive rehabilitation, (including but not limited to, vocational rehabilitation, recreational therapy, or learning exercises);
- Day, night, or residential rehabilitation programs;

- Services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family; and
- Physical and/or functional occupational therapy for first and second degree burns.

Home Health Care

When a patient no longer requires constant care, a hospital or alternative treatment facility setting becomes inappropriate. In such a situation, home health care services of a part-time or intermittent nature may be prescribed by the doctor.

- ***When home health care services are recommended they must be predetermined prior to incurring expenses, to determine if such services are covered by the SHCP and to ensure that the intended provider of such services is approved by the Carrier.*** The Carrier can also determine whether the patient is a candidate for special Program components (such as case management) and interface with the Extended Care Coverage (ECC) Carrier and the DME/P&O Network in appropriate cases;
- Coverage for home health care services is available only when the patient is essentially homebound, and the services are medically necessary.

What Is Covered

When home health care is medically necessary and appropriate, the following services are ***covered, if they are provided on a part-time or intermittent basis*** during a home health care visit and billed by a home health care agency approved by the Carrier. Services provided under home health care coverage include, but are not necessarily limited to, the items below:

- General nursing services;
- Physical therapy and speech therapy;
- Social service guidance, dietary guidance, and functional occupational therapy;
- Home health aide services (if provided in conjunction with general nursing services, or physical or speech therapy services) by an approved health care agency.

The following are covered when provided and billed by an approved provider:

- Laboratory tests;
- Drugs, biologicals, solutions; and
- Medical supplies ordered by the physician and necessary for the home medical regimen.

What Is Not Covered

Services not covered under the home health care provisions include, but are not necessarily limited to, the following:

- Supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances that may be covered under Durable Medical Equipment (DME) or Prosthetic and Orthotic Appliance (P&O) provisions;
- Physician services, private duty nursing, or housekeeping services;
- Skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels;
- Home uterine monitoring;
- Travel time; and
- Services for which the cost would exceed the daily cost for similar care in a skilled nursing facility.

Surgical and Medical

You are eligible for benefits for expenses incurred for covered surgical and medical services when such services are approved by the Carrier and are medically necessary. Your Carrier will pay benefits for covered services based on a fee schedule, capitation schedule or its determination of reasonable and customary charges.

Note: Some provider network arrangements exist for services contained within the surgical and medical coverages. These network arrangements have been established to facilitate the quality and cost competitiveness of services provided.

What Is Covered

Services covered under surgical and medical provisions include, but are not necessarily limited to, the items below. In addition, surgery must be predetermined by Health International for BMP, EMP and PPO options or the Carrier for the POS option.

- Certain surgical services consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of disease, injuries, fractures, or dislocations;
- Certain plastic and reconstructive surgery, such as correction of deformities following cancer surgery or accidental injuries;

  In the case of a participant or Beneficiary who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, under federal law, coverage must include:
  - reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications of all stages of mastectomy, including lymphedemas

  in a manner determined in consultation with the attending physician and the patient;
- Certain dental surgeries (e.g., multiple extractions or removal of one or more unerupted teeth) are covered ***only when performed for a hospital inpatient when a concurrent hazardous condition requiring hospitalization exists;***
- Medically-recognized human organ transplants;
- Voluntary sterilization (but not reversals);
- Laser surgery if the alternative cutting procedure is covered;
- Hemodialysis;
- Anesthesia (by other than the operating physician), including the administration of anesthesia by a lay or nurse anesthetist in the employ of the physician who authorizes the services and who is available for immediate attendance;
- Medically necessary technical surgical assistance, (i.e., services of a physician who actively assists the operating physician) when the services of interns, residents, or house officers are not available;
- Maternity care, including prenatal and postnatal care;
- Consultations when requested by the physician in charge;
- Chemotherapy, both inpatient and outpatient — excluding research, investigational or experimental services;
- Therapeutic radiology;
- Certain diagnostic radiology services;
- Laboratory services;
- PSA Tests
  - Coverage for a screening Prostrate Specific Antigen (PSA) test is provided once every Plan year for enrollees age 40 and over when performed in accordance with guidelines established by the American Cancer Society.
- Certain services related to contraception;
- Physician medical visits in the home, doctor's office, hospital or skilled nursing facility for:
  - Inpatient medical care when provided by the physician in charge of the case;
  - Treatment rendered in or at a hospital when provided by a physician who is not an employee of the hospital;
  - Well child(ren) care for enrollees six years of age or younger; and
  - One physical examination per calendar year for enrollees over six years of age;
- Certain immunizations and injections;
- Foot care for treatment of injuries and/or infections; and
- Screening examinations. (Note: Certain screening exams will not be subject to the deductible or copayment requirements.)

What Is Not Covered

Services not covered under the surgical and medical provisions include, but are not necessarily limited to:

- Certain physician medical visits for:
  - Non-covered services;
    - Acupuncture
    - Allergy testing, treatment, or injections
    - Weight control
    - Manipulation, adjustment, or massage of the musculoskeletal system
    - Services provided by non-physician practitioners (e.g., physician assistants, Christian Science practitioners)
  - Covered services that are billed separately or as a part of other covered services;
    - Prenatal and postnatal care
    - Immunizations
  - Services that are covered under other Program provisions
    - Routine eye exams
    - Mental health or substance abuse treatment
- Dental services including extraction of teeth except as provided for earlier;
- Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, etc.;
- Charges for stand-by physicians or similar charges where no service is actually performed;
- Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting, or similar surgical procedures to correct vision);
- Growth factor treatment for wound care; and
- Thermography.

Ambulance Service

The SCHP provides you with ambulance service coverage when the following three conditions are met:

- Ambulance services must be medically necessary (ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health);
- Services are provided by an approved, licensed ambulance operation; and
- A physician prescribes the services that necessitate use of an ambulance.

What Is Covered

Services covered under the ambulance service provisions include, but are not necessarily limited to, the following:

- Basic life support services that consist of services which provide for the initial stabilization and transport of a patient;
- Advanced life support services (defined as acute emergency treatment procedures with physician involvement);
- Mileage charges while the patient occupies the ambulance;
- Waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital;
- Transportation to the nearest medical facility qualified to provide treatment; transportation to other than the nearest, qualified treatment facility will only be covered in an amount equal to that for transportation to the nearest facility; and
- Air and boat ambulance transportation is subject to individual review and, unless the services of the air or boat ambulance are determined to be medically necessary, will only be covered in an amount equal to that for ground transportation.

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What Is Not Covered

Services not covered under the ambulance provisions include, but are not necessarily limited to, the following:

- Transportation in a vehicle not qualified as an ambulance;
- Transportation for the convenience of you, your family, or your physician;
- Services rendered by providers whose fee is in the form of voluntary donation, for example, fire departments or rescue squads;
- Transfers not medically necessary;
- Services billed by physicians or other independent health care providers for care rendered to enrollees transported by ambulance;
- Services when you are not actually transported while under care;
- Services payable through an existing arrangement to transfer patients where no additional charge is usually made, whether or not such services were immediately available; and
- Services that are covered as a component of the basic or advanced life support services such as:
  - Use of specific equipment or devices;
  - Gases, fluids, medications, dressings, or other supplies;
  - First aid, splinting, or any emergency medical services or personal service procedures; and
  - Vehicle operators, attendants, or other personnel.

Prescription Drugs

Prescription drug coverage for the BMP, EMP, POS and PPO options, is delivered through retail pharmacies participating in the National Managed Pharmacy Network. The National Managed Pharmacy Network pharmacies provide prescription drug services that meet high quality standards. Generally, a participating pharmacy will be located within three miles of your residence. Merck-Medco Managed Care, LLC (Merck-Medco) is the Carrier for this coverage and their logo PAID is reflected on your health care I.D. card.

The network copayment for generic drugs is $5. For brand-name drugs, the network copayment is 25% per prescription or refill with a minimum of $15 and a maximum of $25. For drugs that cost less than the applicable copayment, you will be charged the network cost of the drug.

Locating a Network Pharmacy

There are over 36,000 network pharmacies nationwide. You may call 1-800-711-3459 to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, the customer service representative on the toll-free line will assist you in locating the nearest network pharmacy.

Using a Non-Network Pharmacy

If you have a prescription filled at a non-network pharmacy, you will pay the pharmacist the full cost of the prescription. When you submit a claim form to Merck-Medco, you will be reimbursed for 75% of the reasonable and customary charge after your copayment has been deducted. Claim forms may be obtained via the Internet at www.merckmedco.com, through Apollo from the Benefits Home Page or by calling Customer Service: 1-800-711-3459.

In the event of any emergency, or if you are traveling and cannot locate or access a network pharmacy, your non-network claim for covered prescriptions will be reimbursed at 100% of the reasonable and customary charge after your copayment has been deducted.

Mail Order Prescription Drug (MOPD) Option

If you are taking any medications on a regular basis, you may be able to save money by purchasing your prescription through the mail order option.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 14 days from the date you mail your prescription. You can receive up to a 90-day supply of medication, which saves you money because the mail order copayment is $10 for generic drugs and $20 for brand-name drugs. If your prescription costs less than the applicable copayment, you will be charged the network cost of the drug.

How to Use the Mail Order Option

1. Your doctor may prescribe ongoing medications for up to a 90-day supply, plus refills. If you are now taking medication on a long-term basis, and are **not** currently using the mail order option, ask your doctor for a new prescription.

2. Complete the patient profile questionnaire with your first order. Be sure to answer all the questions.

3. Send the completed patient profile, your original prescription(s), and the appropriate copayment(s) in the order envelope provided. Make sure you sign and complete all the information on the order envelope. Additional mailing envelopes can be ordered on the Internet at www.merckmedco.com.

4. The mail order pharmacy will promptly process your order and send your medications to you via U.S. mail or UPS, along with instructions for future refills. You should receive your medication within 14 days from the date you mail your prescription.

1. Refills can be ordered via the Internet at www.merckmedco.com through Apollo from the Benefits Home Page or by calling 1-800-711-3459.

What Is Covered

Items covered under prescription drug coverage include, but are not necessarily limited to:

- Federal legend drugs that are medically necessary to treat an illness or injury and are prescribed by a doctor. This includes most recognized pharmaceuticals and generic substitutions for federal legend drugs;

- Contraceptive pills and diaphragms;

- Up to a 34-day supply of a covered drug (covered drug means insulin or any prescription legend drug, except as excluded by the SHCP, that is dispensed according to a prescription);

- An appropriate supply of disposable syringes and needles when prescribed for self-injection with a supply of insulin or an antineoplastic or chemotherapeutic agent;

- Transdermal nicotine patches, covered medications or prescription legend drugs used for or in connection with the control or cessation of smoking;

- **Managed Prior Authorization** promotes the appropriate prescribing of certain medications that require careful monitoring for safe use, are high cost, or have a high potential for inappropriate use. ***The dispensing of the following medications must have a coverage review and be approved by Merck-Medco before they will be covered*** under the Basic, Enhanced, POS or PPO options of the Salaried Health Care Program:
  - Accutane
  - Altinac
  - Aricept
  - Avita
  - Avonex
  - Betaseron
  - Cognex
  - Copaxone
  - Epogen
  - Growth Hormones (Geref, Genotropin, Humatrope, Norditopin, Nutropin, Protopin, Saizen, Serostim)
  - Immune Globulins (Gammar, Gamimmune N, Gammagarol, Sandoglobulin and Venoglobulin)
  - Interferons (Aleron, Intron, Roferon, Infergen, Actimmune, Rebetron)

- Myeloid stimulants (Neupogen, Leukine, Neumega)
- Panretin
- Procrit
- Regranex
- Retin-A

Physicians can obtain prior authorization by calling 1-800-458-8001.

- Other medications may require a coverage review only if the length or intensity of therapy is greater than predefined limits based on manufacturers recommendations. Medications which may require a coverage review include:
  - Anzemet
  - Ambien
  - Amerge
  - Chloral
  - Dalmane
  - DiFlucan
  - Doral
  - Enbrel
  - Halcion
  - Hydrate
  - Imitrex, Imitrex NS
  - Kytril
  - Lamisil
  - Maxalt, Maxalt MLT
  - Migranal, Migranal NS
  - Nembutal
  - Placidyl
  - Restoril
  - Sonata
  - Sporonox
  - Stadol NS
  - Toradol
  - Tuinal
  - Zofran
  - Zomig

A coverage review requires that the physician provide additional clinical information to continue the prescribed therapy. The prescription will only be covered if authorization is provided by Merck-Medco Managed Care.

The list of prescription drugs requiring coverage reviews and prior authorization is reviewed on a regular basis and may be modified from time to time.

What Is Not Covered

Items not covered under the prescription drug component include, but are not necessarily limited to:

- Any research or experimental agent;
- Any medication being used for a cosmetic purpose;
- Any medication for the purpose of attempting to induce pregnancy;
- Drugs prescribed for weight control or appetite suppression;
- Devices or appliances (e.g., orthotics);
- Any vaccine administered for the prevention of infectious diseases;
- Any charge for the administration of covered drugs;
- A covered drug in excess of the quantity specified by the physician;
- More than a 34-day supply of a covered drug provided by a retail pharmacy, or for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug option; or
- Drugs received prior to the effective date of the enrollee's health care coverage.

The Maximum Allowable Cost Feature

Your prescription drug coverage includes a Maximum Allowable Cost (MAC) feature that is a generic substitution program. Generic drugs are required to: (1) have the same active ingredients in the same dosage, (2) meet the same quality standards, and (3) have the same medical effect as brand-name drugs, though generic drugs generally cost substantially less. The MAC feature is designed to encourage use of generic drugs by *limiting the amount that will be paid for certain drugs. **If a prescription is written for a drug included on the MAC list and the doctor has not specified that the prescription must be dispensed as written, a generic drug will be dispensed. If you request a brand name drug that is more expensive, you must pay the price difference between the generic and brand name drug, in addition to your copayment.***

If you have a question about your Delphi ***prescription drug coverage***, call a Customer Service Representative at: ***1-800-711-3459.***

Hearing Aid

Delphi provides coverage to address hearing deficiencies or loss once you have been examined by an ear specialist (otologist or otolaryngologist).

What Is Covered

If the examination by an ear specialist determines that your hearing problem may be corrected by use of a hearing aid, benefits may be provided. Following this examination, payment will be made for the following services ***when obtained from a participating or approved provider*** and when provided in the order below, once during any period of 36 consecutive months:

- Audiometric examination (up to the reasonable and customary charge);
- Hearing aid evaluation test (up to $115, effective 10-1-2000 and subject to periodic review and adjustment); and
- One standard hearing aid of the following designs (up to the acquisition cost plus dispensing fee):
  - In-the-ear;
  - Behind-the-ear (including air and bone conduction types); or
  - On-the-body.

What Is Not Covered

Services not covered under hearing aid provisions include, but are not necessarily limited to, the following:

- Audiometric examinations by an audiologist that are not ordered by a physician;
- Medical or surgical treatment;
- Drugs or other medication;
- Audiometric examinations, hearing aid evaluation tests, and hearing aids:
  - Ordered: (1) prior to the enrollee's eligibility for coverage; (2) after termination of the enrollee's coverage; or (3) while covered but delivered more than 60 days after termination of coverage;
  - For which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;
  - Which are not recommended or approved by a physician;
  - Which do not meet professionally accepted standards of practice, including any service or supplies that are experimental in nature;
  - Received as a result of ear disease, defect, or injury due to an act of war;
  - Provided by any governmental agency that are obtained by the enrollee without cost;
  - Provided under any applicable workers' compensation law;
- Replacement of hearing aids that are lost or broken;
- Replacement parts for and repairs of hearing aids;
- Charges incurred by enrollees of an HMO option;
- Eyeglass-type hearing aids, to the extent the charge exceeds the expense for one standard hearing aid;
- Binaural hearing aids except as provided to correct or prevent speech impairment, for ***children under age 19*** who have hearing loss in both ears; and
- Digital-controlled/programmable hearing devices, to the extent the charge for such device exceeds the covered expense for a standard, conventional hearing aid.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliance

When a patient needs to use equipment or appliances that are prescribed by a doctor, they may be covered by your medical plan — whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment, and it is approved by the Carrier.

For employees enrolled in BMP, EMP and PPO options, durable medical equipment and prosthetic and orthotic appliances should be obtained through the Delphi National DME/P&O network, which was created to facilitate high quality, cost-effective care for patients requiring these services.

When covered services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the Carrier. The Carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount charged by the non-network provider which is in excess of the network fee schedule. Additionally, Delphi payments toward the Medicare deductible or coinsurance for those individuals enrolled in the Medicare Program will only be made when services are received from a Network Provider. Your provider may contact the network administrator, Northwood National Provider Network at 1-800-936-9314 for preauthorization, claims processing, assistance in locating participating providers, and for other questions or concerns.

For employees enrolled in a POS option, covered DME and P&O services must be received in the POS network. DME or P&O services received outside the POS network are not covered.

Durable Medical Equipment (DME) — What Is Covered

Equipment and services covered under DME provisions include, but are not necessarily limited to:

- Equipment that meets Program standards which include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;
- Equipment used in a hospital or skilled nursing facility or used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility;
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);
- Neuromuscular stimulators;
- Positioning transportation chairs as alternatives to traditional wheelchairs for child(ren) under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities;
- External electromagnetic bone growth stimulators, in certain cases;
- Portable insulin infusion pumps and home glucose monitors for certain disabilities;
- Pressure gradient supports for certain patients; and
- Pronged and standard canes (when purchased).

Prosthetic and Orthotic (P&O) Appliances — What Is Covered

Appliances and services covered under the P&O provisions include, but are not necessarily limited to:

- P&O appliances that are furnished by an accredited facility and meet Program standards, including being approved for reimbursement under Medicare Part B;
- Orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace;

- Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital;
- Replacement, repair, fitting and adjustments of the appliance;
- Wigs and appropriate related supplies for hair loss caused by chemotherapy or radiation therapy, up to $200 for the first purchase and up to $125 for subsequent purchases after each period of 12 months has elapsed; and
- Through your medical plan Carrier, the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence; (after that, eyeglass or contact lenses are covered under the vision plan).

Durable Medical Equipment (DME) — What Is Not Covered

Equipment not covered under these provisions includes, but is not necessarily limited to, the following:

- Rented equipment which extends beyond the expiration of the original prescription, unless the physician recertifies with another prescription that the equipment continues to be reasonable and medically necessary;
- Deluxe equipment such as motor-driven wheelchairs and beds unless medically necessary;
- Comfort, convenience, self-help, and environmental items not primarily medical in nature, such as adjust-a-beds, elevators, air conditioners, sauna baths, and non-medical supplies such as paging systems;
- Physician's equipment;
- Exercise and hygienic equipment; and
- Experimental, investigational or research equipment.

Prosthetic and Orthotic (P&O) Appliances — What Is Not Covered

Items not covered under this coverage include, but are not necessarily limited to:

- Dental appliances, hearing aids, eyeglasses, elastic stockings, or corrective footwear;
- Foot orthotics; or
- Experimental, investigational or research devices.

Hospice

The SHCP hospice coverage addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility. For terminally ill patients to be eligible for covered hospice expenses:

- The services must be provided and billed by a hospice program which meets Program standards and is approved by the Carrier;
- The enrollee must be admitted to the hospice program by order of a physician who certifies that the patient requires this type of care and has a life expectancy of six months or less; and
- The enrollee must voluntarily elect to participate in the hospice program and agree to accept the services provided as treatment of the terminal condition.

An approved hospice program is limited to a lifetime maximum of up to 210 days.

Services covered under hospice provisions include, but are not necessarily limited to:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a social worker under the direction of a physician;
- Physician services;
- Counseling services provided to the patient, family members, and/or other persons caring for the patient at home;
- General inpatient care provided in a hospice inpatient unit;

- Medical appliances and supplies;
- Physical, occupational, and speech therapies;
- Continuous home care provided during periods of crisis, as necessary to maintain the patient at home;
- Respite care;
- Bereavement counseling;
- Care rendered in a nursing home with hospice support; and
- Home health aide services.

Mental Health and Substance Abuse

The mental health/substance abuse coverages under the SHCP apply to enrollees of the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP), Preferred Provider Organization (PPO) and Point of Service (POS) options of the Program. As a BMP, EMP, PPO or POS enrollee, you receive such services through a managed care arrangement with a network of providers that helps you and your covered family members receive quality, appropriate care.

In the POS plan option, the Carrier is responsible for providing and authorizing covered services through a network of approved providers. For enrollees in the BMP, EMP and PPO options, the Carrier is CIGNA Behavioral Health (CBH).

Participating providers are authorized by CBH to deliver care to you and your family members. You may be directed to the appropriate panel provider by CBH.

All non-emergency inpatient services must be delivered by a participating provider to be eligible for maximum coverage. Emergency detoxification is the only substance abuse treatment service that may be delivered by a non-participating provider. ***Remember, you must use panel providers to receive full benefits.***

CBH has a toll-free telephone number that is available 24 hours a day. If you have questions regarding your mental health/substance abuse coverages or need services, call 1-888-371-0767. Enrollees in a POS plan should call their Carrier with any questions regarding their coverages.

Treatment Options

Mental health and/or substance abuse treatment is generally delivered in one of two ways:

- Inpatient — with an admission to a panel facility; or
- Outpatient — by periodic visits to a participating provider or facility.

A continuing care treatment plan is designed to facilitate effective delivery of services for substance abuse patients. A patient entering detoxification, residential, or halfway house facilities is required to receive a treatment plan as part of his or her assessment. Completion of the plan as prescribed is necessary. If you are an employee and the plan is not completed, you may be responsible for reimbursing the plan up to $1,000 per occurrence toward the cost of treatment.

Inpatient Care — What Is Covered

Services covered under the mental health and substance abuse treatment provisions include, but are not necessarily limited to:

Note: Inpatient treatment can be delivered as hospital care or in one of several alternative treatment facilities. To be covered your stay at an inpatient treatment facility must be approved by the Carrier within 24 hours of your admission. Treatment at a residential facility must always be approved prior to treatment.

- Up to 45 days of approved hospital care or up to 90 days of treatment in an approved partial hospitalization facility during the benefit period, including:
  - Semiprivate room with general nursing services, meals and special diets;
  - Laboratory and pathology (hospital care only) examinations;
  - Drugs, biologicals, solutions, use of equipment and supplies related to the treatment;
  - Professional and ancillary services;
  - Individual and group therapy;
  - Counseling for family members;
  - Electroshock therapy; and
  - Supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients (hospital care only);

- Psychological testing when administered by a panel psychologist and approved by CBH;

- Treatment of mental disorders, limited to individual and group psychotherapeutic treatment, family counseling, psychological testing prescribed or performed by a physician, and electroshock therapy;

- ***Up to 90 days of approved*** skilled nursing facility care for ***mental health services only;***

- ***Up to a 90-day lifetime*** treatment in an approved halfway house for ***substance abuse treatment*** including:
  - Bed and board;
  - Intake evaluation;
  - Up to one routine drug screen per week;
  - Individual and group therapy or counseling; and
  - Counseling for family members.

When both inpatient hospital services and treatment in a partial hospitalization or skilled nursing facility are required, coverage limits take into account the combined treatment. Each day of inpatient hospital care for any condition (including non-mental health or substance abuse conditions) is equivalent to two days of partial hospitalization facility treatment or skilled nursing care.

For example, if an enrollee is admitted to the hospital for one day of inpatient care, coverage may be provided for up to 88 days (90 minus 2) of partial hospitalization or skilled nursing care. Or, after two days of skilled nursing care, an enrollee may be covered for up to 44 days (45 minus 1) in the hospital. One day of inpatient care uses two days of partial hospitalization or skilled nursing care.

Outpatient Care — What Is Covered

*Note: Outpatient treatment does **not** require a hospital stay or admission to a treatment facility. It is delivered during visits to a participating provider. Emergency outpatient treatment requires authorization through the Carrier within 24 hours of your first visit.*

- Outpatient services provided and billed by a facility:
  - Professional staff and ancillary services to ambulatory patients;
  - Prescribed drugs and medications dispensed by a facility in connection with treatments;
  - Electroshock therapy for a mental health patient;

- Outpatient services provided and billed by facilities or professional providers including:
  - Individual psychotherapeutic treatments, group mental health and substance abuse treatment, and family counseling to members of patient's family:
    - 20 mental health visits per year at 100% coverage;
    - Additional 15 mental health visits per year at 75%; and
    - 35 substance abuse visits per year at 100% coverage.

What Is Not Covered

Certain health care services and charges described in the mental health and substance abuse coverage are excluded or limited, as set forth below:

- Panel providers are required to verify eligibility and receive prior authorization for all non-emergency substance abuse treatment;

- Coverage will be limited to the following when rendered by or through non-panel providers:
  - Emergency services. Providers must contact the Carrier within 24 hours of the inpatient admission or outpatient treatment for authorization of such services;
  - Non-emergency services. Benefits for mental health services provided by non-panel physicians without referral by a panel providers are limited to 50% of the panel reimbursement amount. The Carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee;
  - Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with CBH after the first visit and are limited to a maximum of one (1) visit;
  - Substance abuse treatment. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification;
  - Services provided by non-physician non-panel providers are not eligible for payments.

- Coverage is not available for:
  - Services for treatment of mental disorders which are not amenable to favorable modification, except for the period necessary to determine that the disorder is not amenable to favorable modification;
  - Substance abuse treatment professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations unless therapy, counseling, or psychological testing are provided on the same day;
  - Family counseling rendered by a provider other than the provider for the family member in the course of treatment;
  - Diversional therapy;
  - Psychological testing in connection with vocational guidance, training or counseling; or
  - Tobacco use disorder.

General Limitations and Exclusions

Certain health care services and charges described in the previous sections are excluded or limited. The following are some but not necessarily all of these services:

- Services provided after an enrollee's coverage under the SHCP is terminated except for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous predetermined and approved inpatient admissions which commence prior to the termination date of the coverage;
- Private duty nursing services;
- Upgraded room accommodations;
- Dental services;
- Treatment for temporomandibular joint (TMJ) dysfunction;
- Chemotherapy services or supplies when the treatment is research, investigational, or experimental in nature;
- Services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice;
- Care, services, supplies, or devices which are experimental, research, or investigational in nature;
- Personal or convenience items;
- Services for premarital or pre-employment examinations;
- Charges determined by the Carrier to be unreasonable;
- Services related to any condition, disease, ailment, or injury arising out of or in the course of employment for which the employer pays or provides reimbursement under the provisions of any law of the U.S.;
- Services for which a charge would not have been made if no coverage existed;
- Services available through other programs (e.g., Medicare);
- Services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee;
- Care, services, supplies, or devices related to custodial or domiciliary care provided in an institutional setting;
- Care, services, supplies, drugs, or devices for the purpose of inducing pregnancy;
- Travel time or expenses;
- Special education facilities and tutoring for learning disabilities or correction of behavioral problems;
- Food, dietary supplements, or vitamins;
- Services, supplies, or equipment not performed by, prescribed by, or rendered by a physician;
- Charges for miscellaneous services, such as acupuncture, massage, hypnotherapy, etc.;
- Charges for missed appointments, room or facility reservations, completion of any claim forms, or record processing; and
- Bone marrow transplant services under certain conditions.

Extended Care Coverage

When long-term hospital, skilled nursing or custodial care is required, Extended Care Coverage (ECC), provides for certain services not covered by your medical plan. The maximum benefit payable under this coverage for services incurred during any one calendar year is $50,000 for each enrollee. You are eligible for ECC regardless of whether you have elected BMP, EMP, PPO, POS or HMO. The Carrier for ECC is Connecticut General Life Insurance Company.

What Is Covered

Services covered under Extended Care Coverage (ECC) provisions include, but are not necessarily limited to, the following:

- Medically necessary non-custodial hospital or skilled nursing facility admissions which exceed the medical plan limits;
- Skilled hospital or skilled nursing facility admissions which are not covered under the medical plan due to the medical plan Carrier's determination that the admissions are custodial in nature;
- Admissions to ***nursing homes approved by the ECC Carrier,*** for services considered by the ECC Carrier to be skilled in nature;
- Skilled care being provided in the home by a qualified home health care agency or by a qualified nurse professional but which does not meet the criteria for coverage under the medical plan provisions;
- Unskilled care delivered in a hospital, skilled nursing facility, nursing home, or in the patient's home by nurse professionals approved by the Carrier (up to $35 per day); and
- Medical supplies not covered under other SHCP provisions (e.g., prescription drugs, durable medical equipment) for an enrollee admitted to a hospital or skilled nursing facility for unskilled custodial care.

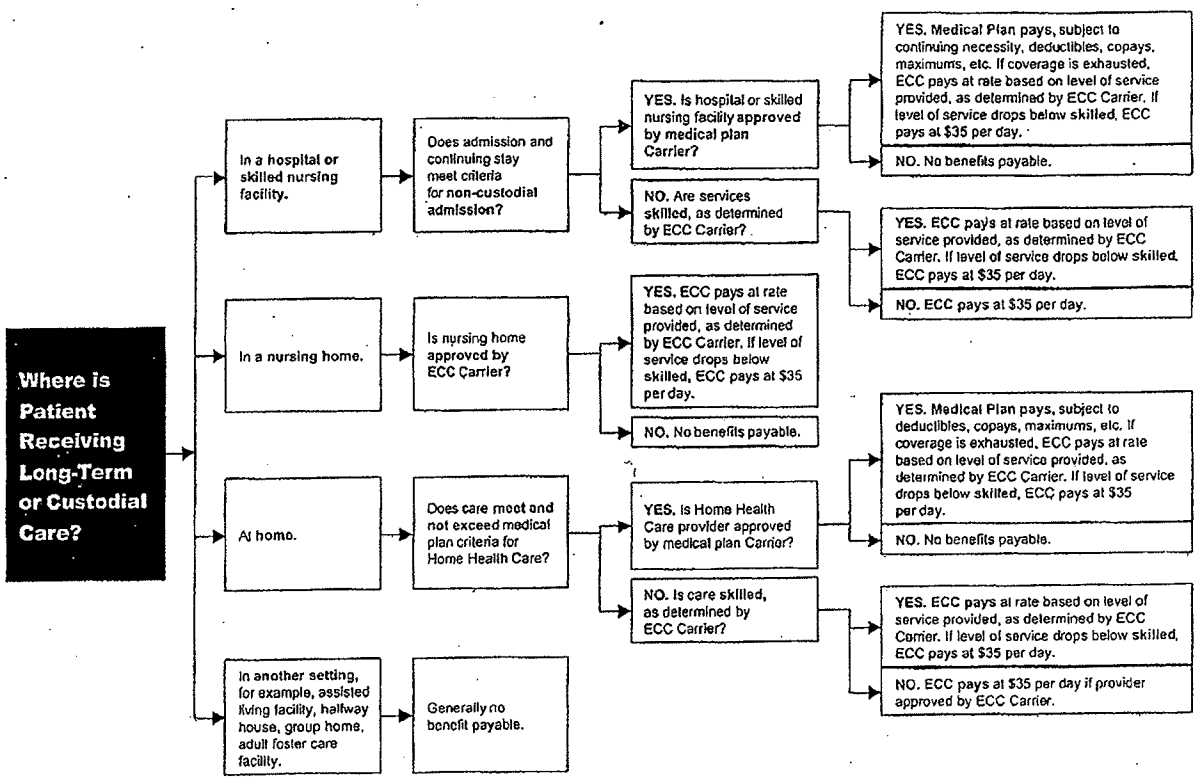
Limitations and exclusions to the ECC coverage include, but are not necessarily limited to, the items below:

- Services in the home in connection with routine nursing care of newborn child(ren);
- Services not prescribed by a physician;
- Education or training (including such services when directed toward learning, behavioral, or developmental deficiencies);
- Amounts covered by public programs providing benefits (such as those under laws pertaining to workers' compensation, non-occupational disability, old age assistance, veteran's assistance, and any federal or state health insurance act providing nursing benefits);
- Amounts reimbursed by Medicare;
- Amounts in excess of the reasonable and customary charge or which are not considered to be necessary as determined by the Carrier;
- Charges which duplicate benefits paid under another section of the SHCP;
- Services provided by a person related to you by blood or marriage;
- Services provided by an assisted living facility, a halfway house, group home, adult foster care facility, and the like;
- Non-medical supplies including, but not limited to, personal hygiene products, over-the-counter medications, and personal items (including disposable briefs and diapers);
- Private duty nursing services for patients admitted to hospitals, skilled nursing facilities, or nursing homes;
- Mental health/substance abuse care exceeding the medical plan coverage; and
- Charges for services rendered prior to the effective date of, or after termination of coverage under the Program.

Further information regarding coverages or claim filing procedures may be received by calling Connecticut General at 1-800-523-4626.

The following chart explains ECC coverages.

Extended Care Coverage



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Dental Coverage

Delphi provides dental care coverage for services and supplies necessary for the treatment of many dental conditions but only to the extent that related charges are reasonable and customary as determined by the Carrier and only if such services are rendered in accordance with accepted standards of dental practice.

Dental coverage is provided through either a traditional option or a managed dental care plan, known as an Alternative Dental Plan (ADP). Delphi's dental coverage has cost-sharing components for participation and for certain services. It also includes limits on the benefits you may receive. ***If a course of treatment is expected to involve covered dental expenses of $200 or more, Carrier predetermination is required. The Carrier for Delphi's traditional dental coverage is JLT Group Services Corporation.***

Under ADPs, to receive full coverage, you must use a dentist who is a member of the plan's network. Benefits may not be provided or may be reduced, if you receive services from a non-network dentist.

Coverage under available ADPs varies from plan to plan and may differ from Delphi's Traditional dental coverage. Specific information about services covered under any available ADP may be requested from the National Benefit Center. You also may call the particular ADP.

Traditional Dental Benefits

If your dentist recommends treatment with an expected cost of $200 or more, a description of the procedure and estimate of the charges should be filed with JLT prior to commencing the course of treatment. After considering alternate procedures, services, and courses of treatment, your Carrier will inform you and your dentist of the charges to be covered for the course of treatment in question.

The predetermination process is not necessary for courses of treatment under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

Failure to file a description and estimate of your course of treatment prior to treatment could result in your being faced with higher than anticipated out-of-pocket expenses.

What Is Covered

Services covered under dental provisions include, but are not necessarily limited to, the following:

- *Preventive* dental services at 100% of the reasonable and customary charge:
  - Two routine oral examinations and cleanings (scaling and cleaning of teeth) within a calendar year; up to three cleanings per calendar year will be allowed if you have a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery;
  - Fluoride treatments, only if under 20 years of age (unless specific dental condition makes such treatment necessary);
  - Space maintainers to replace prematurely lost teeth for child(ren) under 19 years of age;
  - Emergency palliative treatment;
- *Minor restorative* services at 90% of the reasonable and customary charge:
  - Dental x-rays, including: full mouth x-rays once in any five consecutive calendar year period; bitewing x-rays once per calendar year; other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment;
  - Extractions;
  - Oral surgery;
  - Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
  - General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
  - Treatment of periodontal and other diseases of the gums and tissues of the mouth;
  - Endodontic treatment, including root canal therapy;

- Injection of antibiotic drugs by the attending dentist;
- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any three-year period;
- Inlays, onlays, gold fillings, or crown restorations, only when the tooth cannot be restored with other filling restoration;
- Cosmetic bonding of eight front teeth for child(ren) 8 through 19 years of age, under certain conditions, but not more frequently than once in any three year period.

- ***Major Restorative*** services at 50% of the reasonable and customary charge:
  - Initial installation of fixed bridgework (including inlays and crowns as abutments);
  - Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation);
  - Replacement of an existing partial or full removable denture or fixed bridgework under certain circumstances. (Note: Dentures will be customarily replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be covered);

- ***Orthodontic*** procedures and treatment at 50% of R&C (including related oral examinations), for a covered individual ***under 19 years of age when treatment commences up to a lifetime maximum of $1,700 per enrollee.***

- ***Treatment of the temporomandibular joint (TMJ)*** including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models, and casts, temporary splints, and orthotic appliances, limited to $2,000 during the lifetime of the enrollee (it does not include orthodontic treatment, except as in the above); and

- ***Accidental dental injury*** services for repair and/or care of ***natural teeth.*** For this component to apply,
  - The annual maximum benefit must be exhausted;
  - The accident must be documented;
  - The services must be a direct result of the accident and be provided within one year of the accident;
  - Benefits are subject to a reasonable and customary charge, a 20% copayment, and a maximum benefit payment of $12,000 per qualified occurrence and per lifetime.

The ***maximum benefit*** payable for ***all*** covered dental expenses during any calendar year is $1,500 per covered person. For expenses in connection with orthodontics, including related oral examinations, the maximum ***lifetime*** benefit per eligible covered individual is $1,700. For expenses for treatment of TMJ, the maximum ***lifetime*** benefit equals $2,000 per covered individual. For accidental injury the ***lifetime*** maximum is $12,000.

Certain dental care services and charges are limited. Please consult with JLT Group Services Corporation concerning these limitations at 1-800-280-8993.

What Is Not Covered

Services not covered under dental provisions include, but are not necessarily limited to, the following:

- Charges for services covered under other health care coverages;

- Charges for:
  - Treatment by someone other than a dentist;
  - Veneers or similar properties of crowns and pontics for certain teeth;
  - Services or supplies that are cosmetic in nature;
  - Prosthetic devices, crowns, inlays, and onlays and their fitting ordered while you were not covered;
  - Replacement of a lost, stolen or missing prosthetic device;
  - Failure to keep a scheduled visit with a dentist;
  - Replacement or repair of an orthodontic appliance;
  - Services or supplies compensable under workers' compensation or employer's liability law;

- Services rendered through a facility provided or maintained by Delphi;
- Services or supplies that the enrollee is not legally obligated to pay or for which no charge would be made in the absence of dental coverage;
- Services or supplies that are not necessary, recommended, or approved by the attending dentist;
- Services or supplies that are experimental in nature;
- Any duplicate prosthetic device or appliance;
- Completion of any insurance forms;
- Sealants, oral hygiene and dietary instruction;
- A plaque control program;
- Dental implants and/or implantology; or
- Services or supplies related to periodontal splinting.

A Closer Look At Your Dental Options

	Traditional Dental Coverage		Alternative Dental Plan (ADP) (where available)
Monthly contributions	Yes		Yes
Deductible	None		None
Copayment	Plan Pays*	You Pay*	Copayments, benefit maximums, and covered services vary from plan to plan and may differ from the Traditional dental coverage. (Contact the ADPs available in your area for more information.)
■ Preventive	100%	0%	
■ Minor restorative	90%	10%	
■ Major restorative	50%	50%	
■ Orthodontics	50%	50%	
■ TMJ dysfunction	50%	50%	
Maximum annual benefit	$1,500 per covered person		
Maximum lifetime orthodontic benefit	$1,700 per covered person under age 19		
Maximum lifetime TMJ benefit	$2,000 per covered person		
Maximum lifetime accidental dental injury benefit	$12,000 per covered person		

Vision Coverage

Delphi's vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

The Carrier for Delphi's Vision Coverage is MetLife, but will be transitioned to Cole Managed Vision mid-2002. There will be no change in benefits.

What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination per calendar year including refraction, case history, coordinating measurements, and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting, and adjusting of:
  - Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
  - Number 1 or 2 tint for lenses;
  - Contact lenses in lieu of regular lenses (excludes fitting):
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature; or
    - Up to $75 if prescribed for any other reason than those listed above;
  - Frames once during two consecutive calendar years.

What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to, the following:

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the Carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you; and
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

Vision Network

The MetLife national vision network is made up of vision providers who have agreed to accept reimbursement based on a fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to Delphi enrollees at no cost.

Going to a participating network provider will reduce your out-of-pocket expenses. First of all, you will have no copayments or out-of-pocket expense for covered vision services such as a routine vision exam, regular size lenses, certain designated frames that cost less than $55, or medically necessary contacts. Secondly, if you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Finally, there are many popular non-covered lens features whose prices are limited or "capped" under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from MetLife. Information about participating providers in your area is available by calling 1-800-638-0166.

Out of Network

Generally, if you choose to receive covered vision services from a non-participating provider, you will be required to reimburse the provider and file your own claim with MetLife reimbursing you directly based on the regional fee schedule. There is one exception. Your reimbursement for a vision exam provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the Carrier, minus a $7 copay.

Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on reasonable and customary charges as determined by the Carrier, minus a $7 copayment for exams and a $10 combined copayment for lenses and frames.

Summary

This chart summarizes the benefit frequency and the level of reimbursement for covered vision services when received In Network, Out of Network, or Out of Area.

Benefit	Frequency	Network Provider	Out Of Network	Out Of Area*
Vision Exam Optometrist	Once each calendar year.	Covered in full.	Enrollee reimbursed based on regional fee schedule.	Enrollee reimbursed based on R&C** minus $7 copay.
Ophthalmologist		Covered in full.	Enrollee reimbursed based on R&C** minus $7 copay.	Enrollee reimbursed based on R&C** minus $7 copay.
Frames	Once every two consecutive calendar years.	Covered frames available at no cost. 30% discount on non-covered frames.	Enrollee reimbursement $24.	Enrollee reimbursement $16 minus a $10 copay, if applicable.***
Lenses	Once every calendar year.	Covered lenses available at no cost.	Enrollee reimbursement based on regional fee schedule.	Enrollee reimbursed based on R&C** minus $10 copay.
Contact Lenses	Once every calendar year in place of regular lenses.	Enrollee pays difference between provider's charge and $75.	Enrollee reimbursement $65.	Enrollee reimbursement is $75 minus $10 copay.

* *Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
** *R&C stands for reasonable and customary charges.*
*** *There is a combined annual copayment of $10 for lenses and frames.*

Coordination of Benefits

If you or your dependents are covered by another employer's medical, dental or vision plan, the benefits/coverages will be coordinated between the two plans. To determine how to coordinate the coverage under the two plans, it is first necessary to determine which plan pays first.

The primary plan will pay first, without consideration to any other plan, according to the guidelines of its coverage. The secondary plan does not consider a claim for benefits until the primary plan pays or denies the claim. The secondary plan then follows its procedure to determine its payment, coordinated with the payment already made by the primary plan.

It is the Carrier's responsibility to identify if another health care plan is primary. It is your responsibility to notify your Carrier and to respond to inquiries from the Carrier about other possible coverage. Failure to provide the necessary information could result in your claim not being processed for payment.

Because you are an employee, your Delphi plan will be primary for most of your health care claims. If you are also covered as a dependent under your spouse's plan, you should submit your claim to the Carrier of your spouse's plan after your claim has been processed under the Delphi plan.

If your spouse is covered by your Delphi SHCP coverage and if your spouse is employed and covered under his or her employer's plan, then that employer's plan is the primary coverage for your spouse's claims.

Your spouse's claim should be submitted to the Delphi plan after being processed under the spouse's plan.

If your dependent child(ren) is covered by both your plan and your spouse's plan the "Birthday Rule" applies.

The Birthday Rule

The primary plan for your child(ren)'s coverage is the plan of the parent whose birthday comes first in the calendar year. If you and your spouse have the same birthday, then the plan that has covered your child(ren) for the longer period of time is primary.

A different guideline applies for your dependent child(ren) if you are ***divorced or legally separated.*** In this situation:

- The plan of the parent who has legal custody of the dependent child(ren) is that child(ren)'s primary plan unless an appropriate court order states otherwise; and the plan of a stepparent with whom the child(ren) resides will pay before the plan of the parent without custody.

If none of these rules establish which plan is primary, the plan that has covered the person for the longer time becomes the primary plan.

When the Delphi SHCP Is Secondary for a Claim

The Delphi SHCP calculates the amount it would pay as if there were no other coverage. The amount of benefits actually payable by the other plan for services covered by the Delphi plan is then subtracted from the amount the Delphi plan would have paid. The Delphi plan pays the difference, if any. In other words, if the primary plan's payment meets or exceeds the amount the Delphi plan would have paid alone, no further payment is made. ***Through the coordination of benefits process, you cannot receive any more than the total amount of the charge.***

When there are multiple coverages, you must first file the claim with the primary health care plan. After you have received written notification of payment or denial from the primary Carrier, you should make a copy of it and submit it to the Carrier of the secondary plan.

Under the Delphi SCHP, you will receive credit toward satisfying deductibles and out-of-pocket maximums ***even though the primary plan,*** rather than you, ***is making the payment.*** Delphi uses a similar arrangement to coordinate payments from its plan with those paid by Medicare Part B, for individuals who have Medicare coverage that is primary.

Coordination of Benefits Example #1

John is married to Mary, a Delphi salaried employee who elected the Basic Medical Plan for herself and her spouse. John has other coverage through his employer, and it pays 70% of covered expenses with no deductibles. That coverage is primary for John. The Delphi coverage he has through Mary is secondary.

Assume that John submits a bill for $200 in covered expenses and that the deductibles applicable to Mary's Delphi coverage have already been satisfied for the year. Here's how benefits would be paid:

John submits the expense to his plan which is primary:

Expense	$200
His plan pays 70%	$140
Remainder	$ 60

After payment from his primary plan, John submits the total expense to the Delphi Basic Medical Plan, along with a statement of payment action by his plan.

Expense	$200

What the Basic Medical Plan would have paid:

At 75% if it were John's only coverage	$150
What John's primary plan paid	$140
What the Basic Medical Plan will pay	$ 10

Credit applied to the out-of-pocket limit for John under the Delphi Basic Medical Plan ($200 - $150)	$ 50

Coordination of Benefits Example #2

Bob is a Delphi salaried employee who elected traditional dental coverage. Bob's spouse, Sue, has dental coverage through her employer which covers most procedures at 80% of reasonable and customary charges as determined by the Carrier. Assume that Sue recently had covered expenses of $200 and that the charges were not greater than either Carrier's determination of reasonable and customary.

Since her plan is primary these expenses were first sent to her dental plan administrator for consideration.

Expense	$200
Primary pays 80%	$160

After the payment from her primary plan is received, Bob can submit the dental services received by his spouse for additional consideration under Delphi dental coverage, along with a statement of payment action from the primary plan. Assume in this case that the procedures performed are payable at 90% of reasonable and customary charges as determined by the Carrier under Delphi dental coverage.

If Delphi dental coverage had been primary:

Expense	$200
Delphi dental pays 90%	$180

What Delphi dental coverage will pay as the secondary payer

Delphi dental plan would have paid	$180
Primary plan paid	$160
What Delphi coverage will pay	$ 20

The amount applied toward Sue's annual maximum at Delphi will be what Delphi would have paid or $180. Sue's remaining calendar year maximum is $1,320 ($1,500-$180).

Administrative Provisions

How to File a Claim

Claims should be filed with the appropriate Carrier as services are rendered and expenses are incurred. However, ***claims for all health care services must be submitted not later than the end of the calendar year following the year in which services are rendered.*** Claim forms are available through Apollo at the Benefits Home Page or from the Carrier.

Your Social Security number is always needed when you communicate with any of the Carriers. If you are a dependent, the Social Security number of the employee, retiree, or surviving spouse through whom you have the coverage is needed.

Hospital, Medical, and Surgical Claims for BMP, EMP and PPO

If your Carrier is a Blue Cross or Blue Shield plan, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Usually, a hospital or other facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office.

If your Carrier is United HealthCare, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Payment will be made directly to the provider, unless you have paid all or part of the charges for covered services. In that case, United HealthCare will pay you the appropriate amount.

Prescription Drug Claims — BMP, EMP, PPO and POS

When you use a network provider, your claims for services will be filed electronically with Merck-Medco by the provider. If you obtain services from a non-network provider you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling Merck-Medco. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

Mental Health and Substance Abuse Claims — BMP, EMP and PPO

Because the mental health and substance abuse coverages utilize a closed panel of approved providers, the facility, or other provider, generally will have a supply of claim forms.

If it becomes necessary for you, instead of the facility or provider, to submit a claim form to Connecticut General Life Insurance Company (CG) (e.g., you receive outpatient mental health treatment from a non-panel physician provider to whom you must make payment before you may seek reimbursement from CG), you are required to send the originals of either (1) itemized bills, (2) statements, or (3) receipts for each of the medical expenses for which you are claiming payment.

Hearing Aid Claims

Because only approved or participating providers are eligible for reimbursement, such providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the Carrier. ***Benefits are payable only if you obtain hearing aid services from a participating provider, and only if they are obtained in the appropriate sequence.*** Ask the provider if he or she is participating ***before*** you receive services. If you need the name of a participating provider, inquire with the appropriate Carrier.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Claims — BMP, EMP and PPO

Durable medical equipment and prosthetic and orthotic appliances should only be obtained from the Delphi National DME/P&O network. By using network providers, you will not have to file claim forms, nor will you receive balance due billings from providers.

When covered items or services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the Carrier. The Carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount due to the provider that is in excess of network fee schedules.

Contact the network administrator, Northwood National Provider Network, at 1-800-936-9314 with any questions pertaining to the network.

Point of Service Option — Claims for Covered Services

The Carriers for the POS option include, Blue Cross Blue Shield of Michigan, Health Plus, and CIGNA Health Care.

The POS Carriers are responsible for the administration of all the covered services under the Salaried Health Care Plan with the exception of Prescription Drug Coverage.

As long as services are received from your primary care physician (PCP) or by referral through the PCP or the Carrier there will be no claim forms to complete.

If you receive covered services outside the POS network or without referral by your PCP then a claim form provided by the POS must be completed by you in order to receive reimbursement. In these situations, the Carrier will reimburse you based on the network fee scheduled minus any deductibles and coinsurance. You will be responsible for paying the provider(s) who rendered the services.

Dental Claims

In areas of the country where Delphi has business operations, most local dentists are able and willing to file claims on behalf of Delphi enrollees. However, claim forms are also available through Apollo at the Benefits Home Page or from the Carrier.

If a course of treatment is expected to involve dental expenses amounting to $200 or more, prior to the commencement of treatment, you should have your dentist submit a description of the procedures to be performed and an estimate of the charges to JLT Group Services. JLT Group Services will notify the dentist and you of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results.

Vision Claims

MetLife is the current vision coverage Carrier. A claim form may be obtained from a participating provider or MetLife. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to MetLife. Payment will be made directly to a participating provider, unless you have paid all, or part, of the charges for covered services. In that case, MetLife will pay you the appropriate amount. Payment for covered services received from a non-participating provider will be sent to you.

Extended Care Coverage (ECC)

You should obtain the necessary forms from Connecticut General by calling 1-800-523-4626. ***There are things you should do routinely to prepare for filing the claim:***

- Obtain all bills and receipts for medical services incurred by you and your covered dependents;
- Be sure bills and receipts are properly identified, separated by individual, and in chronological order;
- Ensure that the bills or receipts are itemized and include the patient's name, description of service or medical supply, date of service or purchase, and charges incurred;
- Submit "Explanation of Benefit" statements from your medical coverage Carrier and, if applicable, "Medicare Explanation of Medicare Benefit" statements, with appropriate bills or receipts;

- Be sure that receipts for medical supplies, equipment, private duty nursing, physical therapy, or other services not performed by a physician are supported by certification of the attending physician and that such supplies, equipment, or services are medically necessary; and
- Be sure that claims are filed in a timely manner.

Appealing a Claim

Whenever you have questions regarding your health care coverages you should first contact the appropriate Carrier. Health Maintenance Organizations (HMOs) and Alternative Dental Plans (ADPs) have their own appeal process which must be followed in all circumstances. HMOs and ADPs are responsible for formulating their own medical policy. Decisions resulting from their appeal process regarding medical policy are final and binding. If you are enrolled in the Basic Medical Plan, Enhanced Medical Plan, Preferred Provider Organizations, Point of Service or traditional dental coverage you should follow the process outlined below.

If you have questions regarding the Carrier's processing of your health care claim, write to your local Carrier and include in your correspondence the following:

- The Explanation of Benefits (EOB) you received from the Carrier;
- Any additional information/ documentation to be considered; and
- The reason why you believe the Carrier's processing should be reviewed.

The Carrier will review the information and provide further explanation of its processing of the claim.

If you still have questions about the Carrier's processing of your claims you may write to the Plan Administrator at the National Benefits Center, P.O. Box 5175, Southfield, Michigan 48086-5175, including with your correspondence the following:

- The initial EOB;
- The Carrier's further explanation;
- The basis for requesting a determination by the Plan Administrator; and
- Other pertinent documentation.

It is the Plan Administrator's role to determine whether the SHCP provisions have been applied properly and consistently. For services determined to be research, experimental or investigational in nature an additional review step may be made available. ***The Plan Administrator does not have the authority to grant exceptions to the SHCP nor is the appeal process intended for this purpose.***

The Plan Administrator will respond in writing by either approving or denying your claim. You will then have 60 days to appeal a denied claim by writing to the Secretary of the Employee Benefits Plan Committee (EBPC), Mail Code 480-414-456, 1450 W. Long Lake Road. Troy, Michigan 48098. As part of this appeal, you must provide any written documentation to support your position that the SHCP provisions have not been properly applied. The EBPC of the Corporation, which has been delegated authority to construe, interpret, apply and administer the Program, is the final review authority with respect to any appeal. The decision of the EBPC is final and binding. Requests for exceptions to the SHCP provisions may not be appealed to the EBPC.

Effect of Medicare

You become eligible for Medicare at age 65, whether or not you choose to continue working. However, if you continue to work after age 65, Social Security will not notify you of your eligibility to enroll for Medicare. ***It is your responsibility to contact the local Social Security Administration office to apply for Medicare***, whether or not you are working when you attain age 65. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment.

If you or one of your dependents have a severe long-term disability, end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fit one of these categories, you should contact your nearest Social Security Administration office to have your case evaluated.

Generally, you or your dependents will want to enroll for Medicare when you first are eligible to do so. This is true not only because of penalties which may be incurred in Medicare premiums, but also because Medicare may cover services not covered by the Delphi Program. ***Moreover, eligibility for Corporation contributions for coverage may depend on Medicare enrollment.*** For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any Delphi health care coverages if your spouse is eligible, but is not enrolled, for Medicare Part B at or after age 65.

If you are working, and you (1) are over age 65, or (2) have a dependent who is eligible for Medicare, you may elect to have coverage under both the Delphi SHCP and Medicare. Generally, if you do so, the Delphi SHCP will be the primary source of benefits (the first to pay for any covered services). Usually, it is in your interest to apply for Medicare hospital insurance (Part A). No premium is required if you have enough work credits under Social Security, and Part A can supplement the Delphi SHCP. Enrollment in Medicare medical insurance (Part B) is required for your age 65 or older surviving spouse to receive Corporation contributions for coverage in the event of your death (see preceding paragraph).

If you retire and are enrolled in Medicare, Medicare will become the primary source of benefits for you and your dependents who also are enrolled for Medicare. Benefits otherwise payable under the Delphi SHCP will be adjusted to reflect the amount of benefits payable by Medicare for the same covered services. The Delphi SHCP will supplement Medicare, to the extent the Delphi SHCP covers services Medicare does not cover. Your health care claim first must be filed with Medicare. After Medicare pays its portion, the claim should be sent to the appropriate Delphi Carrier. In some areas arrangements have been made for Medicare to electronically submit claims to your Delphi Carrier, after Medicare has paid its portion.

This arrangement is called "Medicare Crossover" and may minimize your involvement in the claims handling process. You should contact your Carrier to determine if Medicare Crossover is available in your area.

Most health maintenance organizations (HMOs) do accept Medicare enrollees; however, those plans generally require enrollment in both Part A and Part B, if eligible. If you are enrolled in an HMO, you must follow the guidelines of the HMO regarding Medicare claims processing.

The Balanced Budget Act of 1997 made some changes in the Medicare program. The law includes a section called Medicare+Choice that creates new health plan options. All Medicare Beneficiaries will receive annual mailings and information from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare.

You should keep in mind that these mailings are not connected in any way with the Delphi Salaried Health Care Program. The CMS (Medicare) materials will not explain how the changes apply to you and your SHCP coverage.

To continue your Delphi coverage, you will not need to do anything in response to the CMS (Medicare) mailings. In fact, if you do join an HMO not offered by Delphi, or if you elect a plan outside of the annual Delphi enrollment process, you may be putting your Delphi-sponsored coverage at risk.

Special Benefit

If you are eligible for Corporation contributions for health care in retirement, and you are enrolled in Medicare Part B, and are a ***(1) retiree or surviving spouse receiving a Delphi monthly Part A retirement benefit,*** *or* ***(2) disabled employee eligible to receive Extended Disability Benefits,*** you may be eligible to receive a full monthly Special Benefit for each month you maintain Medicare Part B enrollment. The amount is equal to the lesser of the Medicare Part B premium or $61.50, and will be included in your monthly Delphi retirement check or Extended Disability Benefit check. Also, under current federal income tax law, because receipt of the Special Benefit is conditioned on your Medicare Part B enrollment as verified by Delphi, the Special Benefit will be non-taxable.

This Special Benefit also is payable, upon application, to an eligible retiree or eligible surviving spouse who is (1) receiving Delphi monthly Part A retirement benefits, (2) under age 65, and (3) enrolled in Medicare Part B.

Evidence satisfactory to Delphi of your enrollment in Medicare Part B is required for you to receive a Special Benefit. If evidence of enrollment is not provided in a timely manner, retroactive payment of the Special Benefit will be limited to 12 months. Any recipient who is enrolled in Medicare Part B coverage will have the Special Benefit discontinued for periods during which Medicare Part B enrollment is not maintained.

The Special Benefit is ***not*** payable to any: (1) former employee receiving a deferred vested retirement benefit, or (2) surviving spouse receiving a survivor benefit resulting from a deferred vested retirement benefit.

No more than one Special Benefit is payable to any individual for any one month.

Reimbursement for Third-Party Liability

Occasionally a person may sustain an injury and incur health care expenses because of another party's wrongdoing. While Delphi does not suspend coverage while liability is being determined, Delphi should not bear the financial burden if another party is responsible. Consequently, if (1) Delphi pays benefits on behalf of you or one of your dependents, and (2) you recover any monies from a third party for the same expenses, you are expected to reimburse the SHCP.

You must provide notice to the Corporation (or to your health care Carriers on behalf of the Corporation) of any such recovery (or effort to recover) from a third party. You are required to assist in the recovery effort. In this regard, you should note:

- Delphi assumes your right to recover payment from any third party, up to the extent of such third party's liability;
- If you recover any monies through lawsuit, settlement, or other means, you must reimburse Delphi for benefits paid;
- You grant Delphi a lien on any monies you or your Beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages;
- You grant Delphi the right to intervene in a lawsuit for the purpose of enforcing the Delphi's lien;
- You grant Delphi the right to recover its legal fees and costs that exceed Delphi payment of benefits from any recovery;
- You agree to inform Delphi when you engage an attorney to pursue a claim, and to inform your attorney of Delphi rights under the SHCP, and
- You agree not to settle any claim or take any action that would prejudice Delphi's rights or interests.

Comparison of Delphi Health Care Program Coverages for U.S. Regular Salaried Employees

Medical Plan Coverages	Basic Medical Plan (BMP)	Enhanced Medical Plan (EMP)	Preferred Provider Organization (PPO) (where available)	Point of Service (POS) (where available)	Health Maintenance Organization (HMO) (where available)
■ Hospital ■ Skilled nursing facility ■ Physical, functional occupational and speech therapy/cardiac rehabilitation coverage ■ Surgical and medical coverage ■ Ambulance service coverage ■ Hospice coverage	For the services listed, scope and level of coverage are identical for BMP, EMP and PPO, subject to various plan limits. The scope and level of coverage under the POS option is similar to BMP, EMP and PPO, but certain plan limits may be waived if services are received in the POS network through your Primary Care Physician.				Varies by HMO
■ Home health care ■ Hearing aid coverage ■ Durable Medical Equipment/ Prosthetic and Orthotic appliance coverage (DME/P&O)	For the services listed, scope and level of coverage are identical for BMP, EMP, PPO and POS, subject to various plan limits. Under POS, these services are only covered if received in the POS network or by a referral.				
■ Mental health and substance abuse coverage	Scope and level of coverage are identical for BMP, EMP, PPO and POS and are subject to separate copayment provisions and limitations. Generally, services must be approved by the Carrier and received within the Carrier's network.				
■ Prescription drug coverage (per prescription)	Retail: Generic $5, brand-name 25% with $15 minimum/$25 maximum Mail-order: Generic $10/brand-name $20 Must use the National Managed Pharmacy Network for full reimbursement.				
Extended Care Coverage (ECC) ■ Hospital ■ Skilled nursing facility ■ Nursing home ■ Home nursing ■ Custodial	Included with BMP, EMP, POS, PPO and HMO medical options ■ Provides for certain long-term and/or custodial care needs, either not covered or that exceed medical plan limits ■ $50,000 maximum benefit per individual payable during any one calendar year				
Dental Coverages	**Traditional Dental Plan Coverage**			**Alternative Dental Plans (where available)**	
■ Preventive ■ Minor restorative ■ Major restorative	100% 90% 50%	(Combined annual maximum benefit per individual of $1,500)		Varies by Plan	
■ Orthodontics (under age 19)	50% ($1,700 lifetime maximum per covered person)				
■ Temporomandibular joint dysfunctions (TMJ)	50% ($2,000 lifetime maximum per covered person)				
■ Accidental Dental Injury	80% ($12,000 per qualified occurrence and per lifetime)				
Vision Coverage	Vision examinations — Once during a calendar year by either an optometrist or ophthalmologist Lenses — Once during a calendar year Frames — Once during two consecutive calendar years National Vision Network — There is no out-of-pocket expense for covered services when received from a participating provider. (Out-of-pocket expenses will be incurred if certain frames or lens features are selected.)				